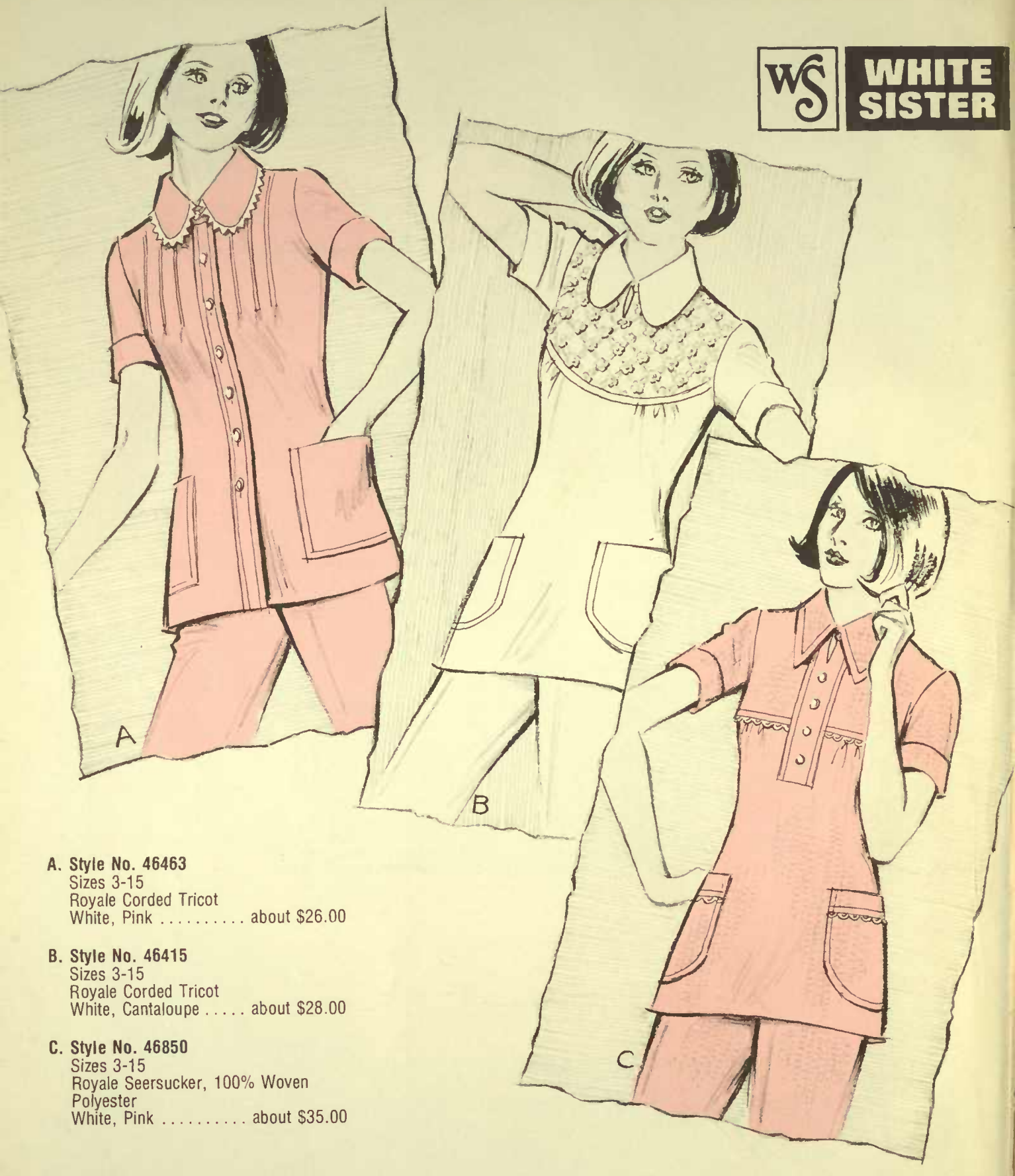
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Volume 72, Number 1

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Cover Photo:
Health and Welfare Canada
Communications services in Canada's far north are presently undergoing expansion and revitalization as a result of technological progress. For nurses in the north, such as the one featured on this month's cover, these improvements mean better health care for their patients. Read *Nursing via Satellite* on page 31.



The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses' Association.

ISSN 0008-4581

Indexed in International Nursing Index, Cumulative Index to Nursing Literature, Abstracts of Hospital Management Studies, Hospital Literature Index, Hospital Abstracts, Index Medicus. *The Canadian Nurse* is available in microform from Xerox University Microfilms, Ann Arbor, Michigan, 48106.

The Canadian Nurse welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-space. Send original and carbon. All articles must be submitted for the exclusive use of *The Canadian Nurse*. A biographical statement and return address should accompany all manuscripts.

Subscription Rates: Canada: one year, $8.00; two years, $15.00. Foreign: one year, $9.00; two years, $17.00. Single copies: $1.00 each. Make cheques or money orders payable to the Canadian Nurses' Association.

Change of Address: Notice should be given in advance. Include previous address as well as new, along with registration number, in a provincial nurses' association where applicable. Not responsible for journals lost in mail due to errors in address.

Postage paid in cash at third class rate Montreal, P.Q. Permit No. 10,001.
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Edito

What is there to say about a change in format as radical as the one which faces readers of *The Canadian Nurse* and *L'infirmiere canadienne* this month?

Either you like it or you don't. Obviously, we hope very much that you do like it. We present it in good faith, relying on the combined expertise of a skilled young graphic artist, an innovative printer, and our own collective editorial opinions as to what you expect from your professional journal.

Plans for the new format began almost a year ago. Development has proceeded slowly, allowing for lengthy consultations between the artist, the staff of both journals, the printer and other CNA staff members. All of this planning will see its first concrete expression in this January, 1976 issue.

At this stage, two weeks before press time, about all the editor can do is keep her fingers crossed and hope for the best. It is inevitable that there will be mistakes in this first trial run; I only hope they will not be big mistakes and that readers will remember how difficult the first few weeks under a new system can be.

As for the technical details — those of you who have had some publishing experience will recognize the work that has gone into the new format. Type faces and sizes are different throughout the book. Column sizes have changed: departments (news, letters, etc.) now appear in new, narrower versions, four columns to a page. Some of the names of these departments have been updated to try to match the mood of the seventies.

Most of all, there is a bold new design for the cover — one new look for both the English and French editions. This design will remain constant but the photos and color combinations will change with each issue.

So much for the medium — what about the message? We have a new vehicle and, therefore, an obligation to make the contents live up to the format. One of the ways we will be trying to accomplish this is by accepting the constructive criticism offered by your provincial public relations officers. These representatives met recently with their national counterparts at CNA House to examine their respective roles as providers of information at national, international and provincial levels. Their comments will play a major role in editorial decisions over the coming months.

Among other things, they said: tell us more about national health issues (not just nursing); give us more controversial articles; give us more clinical (how-to) articles; try to reflect more closely the views of the average staff nurse; and let us know more about what our national association is doing for us.

They also said: try to be less impersonal; try for a less scholarly, less pedantic approach; above all, look like you're having fun.

Promises are easy to make and hard to keep. But those are suggestions we are going to try to live with, especially the last one.

—M.A.H.

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Herein



There is something special about this January 1976 issue of *The Canadian Nurse* that doesn't immediately meet the eye. For the past ten years, address labels for both CNA journals have been produced by computer, using a service provided by IBM Ottawa Data Centre. This issue, however, comes to you via a new System 3 Model 8 computer that now resides at CNA House. Installation (pictured above) took place late last Fall and since then, circulation staff have been working overtime to get the system operating.

The main advantage to you, the reader, will be faster and more efficient delivery of your journal. Our thanks to all 120,000 of you for your co-operation and patience in this change. If a problem should arise with your own subscription, or if you know of someone who hasn't received the copy, help us get things straight. The information we need:

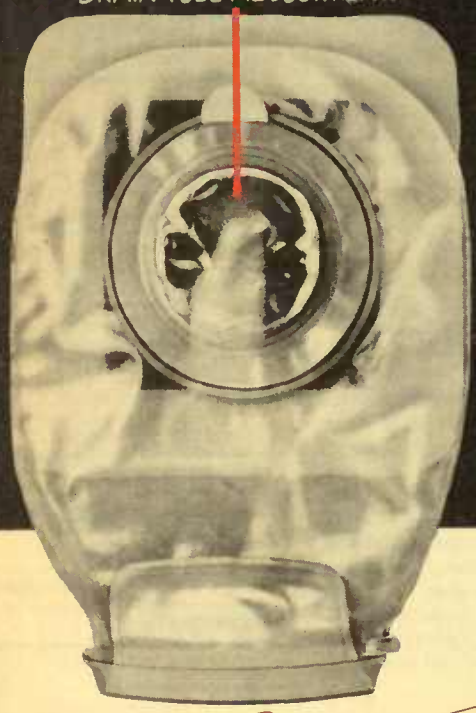
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Next month in *The Canadian Nurse*, three nurses who work in Canada's first multidisciplinary stroke unit at Sunnybrook Medical Centre in Toronto share their experiences with readers. Patricia Adolphus, Catherine Pallant and Linda Graham have each worked with stroke victims for several years. In their three-part article next February, they describe the history of the unit, the physical layout, the nursing care involved, and the rehabilitation of stroke victims.

Happy New Year

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The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

Input

OOPS, WE GOOFED ... in the report on the last meeting of CNA Directors* (The Canadian Nurse, *December, 1975, page 33) the statement on predicted costs of the 1976 CNA convention should have read as follows: Since it is estimated that convention costs will increase by close to $15,000, registration fees will have to be increased to help cover expenses."

Why Such a Long Wait?

In the July 1975 issue of *L'infirmière canadienne* it was suggested that nurses considering going to work in a foreign country would be well-advised to secure authorization from that country before leaving Canada. I am writing to tell you of a similar experience right here in our own country.

I wanted to leave Quebec to work in the province of Ontario, looking for new surroundings and new experiences. Of course, I intended to work in the field of nursing which is familiar to me. I had to wait eight months for the transfer of my license and I cannot tell you how many useless letters I received while I waited for the necessary papers.

Travel can be enriching but if you have to make your decision a year ahead and delay your departure another eight months waiting for your license, the spontaneity of the whole project vanishes.

Why such a long wait? It seems to me that a study of this situation would be in order. I urge those who have experienced similar hardships to send their comments. Perhaps your next trip will be smoother and more pleasant?
— *L.P.T., N., Québec.*

As you suggested, CNA's Information Service has conducted a study of problems related to the registration process in various provinces. We urge you to read the article entitled "Cross-Canada Registration" that appears in this issue of both The Canadian Nurse and L'inlirmière canadienne.

Nursing Positions Scarce?

A copy of the following letter to the Ontario Minister of Health was sent by the author to the editor of The Canadian Nurse. *It is published here, with the permission of the author, as an indication of a situation which could have a direct or indirect bearing on the social and economic welfare of readers. If you have firsthand knowledge of similar situations, we would welcome your letters.*

The Honorable Mr. F. Miller,
Minister of Health,
Parliament Buildings,
Queen's Park,
Toronto, Ontario.

I am a recent graduate from George Brown College — Nursing Division, Nightingale Campus.

In June of 1975 I was hired by the Doctors Hospital and the Toronto Western Hospital as a Graduate Nurse with registration pending. At this time I accepted the Doctors Hospital's offer of employment and consequently rejected Toronto Western Hospital's.

In the first week of August, one month before I was to begin working, I was informed by Dr. V. Kirkpatrick, the Director of Nursing Services at the Doctors Hospital, that the job offer had been withdrawn due to budget difficulties.

Since that time, although I have been actively searching for a job (nursing home at Christie and Bloor, Cancer Society, Red Cross, City of Toronto, Ministry of Community and Social Services, Manpower, YMCA, Mount Sinai, Hillcrest, Wellesley, Toronto General, Salvation Army — Grace, Toronto Western (again), Women's College, Central, and Princess Margaret,) I have been unable to find a nursing position because all vacancies had been filled in May and June for Graduate Nurses.

I feel that I was unjustly treated by the Doctors Hospital because they had confirmed my position, and then withdrew it when it was too late for me to find another job.

I find myself now in great difficulty as a direct result of their unethical conduct. Having tried everything else I must now ask that the Doctors Hospital fulfill its obligations. I appeal for your help immediately. — *Lynda Hirtenfeld, Toronto, Ontario.*

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Ulcerative: Varicose ulcers, diabetic ulcers, bedsores, tropical ulcers.
Thermal: Burns, scalds.
Elective: Skin grafts (donor and recipient sites), avulsion of finger or toenails,circumcision.
Miscellaneous: Secondarily infected skin conditions – eg. eczema, dermatitis, herpes zoster, colostomy, acute paronychia, incised abscesses (packing), ingrowing toenails.

Contraindications
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News

Bright Future Predicted for Nursing Research

All "indicators" point towards a healthy future for research in Canada. This was the conclusion reached by participants in the three-day 1975 National Conference on Nursing Research in Edmonton in November.

"Development and use of indicators in research" was the conference theme. The 68 delegates heard three internationally known nurse researchers explore use of social, physical and psychologic indicators. Five major papers (each followed by critiques by two other expert researchers) and eight mini-papers on specific Canadian projects were also read.

Presentations were chosen to illustrate use of indicators and explore the question:"Does nursing make a difference?"



Director of the 1975 National Conference on Nursing Research, Shirley Stinson, makes notes during an address by June C. Abbey, assistant professor and acting chairperson of the department of nursing in biological dysfunction, University of California, San Francisco. At right is Jack Hayward, principal nursing officer with the department of health and social security in London, England, and another keynote speaker.

What is an indicator?

"Basically an indicator is a person or thing that points out — a pointer," keynote speaker, Lisbeth Hockey, explained during the opening address. "In relation to nursing research, an indicator may be a pointer to a phenomenon relevant to nursing knowledge and nursing research that attempts to extend that knowledge."

Hockey, who is director of the nursing research unit in the department of nursing studies at the University of Edinburgh, Scotland, warned Canadian researchers of the need to be aware of overall social indicators since these have important implications for their own studies.

Canadian studies

Canadian presentations were chosen from a list of 47 projects currently underway or recently completed.

The most complex was one being carried out under principal investigator Dr. Moyra Allen at McGill University. This project, now entering phase two of a five-year program, is concerned with development of instruments, questionnaires, audio-and videotape reviews and observations by expert nurse-judges and other health professionals to measure critical variables (or differences) in the expanded functions of nurses in three types of settings— a general hospital, a community health center, and a new type of special health and community resources center.

Marian McGee, associate professor, faculty of nursing, University of Western Ontario, described a project in London, Ontario, to determine how well community nurses can assess a family's ability to make decisions.

"Since... the family decision-making is the basis of all family functioning, then the extent to which family decisional skill is accurately assessed and subsequently modified is one measure of effectiveness of Community Health Nursing," McGee said in her abstract. Her project is working on existing instruments and looking at ways these can be modified to be effective indicators.



Some of the 68 delegates from seven provinces who attended the recent 1975 National Conference on Nursing Research in Edmonton. The conference was the fourth to be held in Canada.

Another project is being carried out by Jeanette Funke, assistant professor, school of nursing, University of Alberta. Its purpose is to test the reliability of current instruments (such as questionnaires and evaluation sheets) and possibly create new ones that will indicate how women adapt to pregnancy and to their newborn babes.

Two completed studies

Fabienne Fortin, doctoral candidate, University of Western Ontario, described a project recently completed at a large Montreal hospital.

This study evaluated a structured preoperative patient education program and found that preop education by nurses *does* make a difference. Patients receiving the preop education program were less impaired by surgery when measured against a specific set of desired outcomes (such as ability to walk, go to the bathroom normally and so on) than patients in a control group who did not receive the program. The differences were most pronounced at two and ten days after the operation, but considerable differences were still found 33 days postoperatively.

Vivien Jenkinson, nursing systems analyst, Hospital for Sick Children, Toronto, undertook to develop a reliable measurement tool that could be used to quickly and effectively judge the quality of nursing care of children. The final, single-page, evaluation sheet—called SAVE from the full title of Selected Attribute Variable Evaluation—contains 22 items and will allow head nurses, team leaders or other observers to assess the quality of nursing care given by any one nurse to any one child at any time. More than 1,000 evaluations have been completed since SAVE came into use at the hospital in March,1975.

Planning future conferences

The director of the 1975 conference was Shirley Stinson of The University of Alberta. Four university schools of nursing in the Prairie provinces were represented on the planning committee. Delegates agreed to ask the Canadian Nurses' Association for secretariat assistance in planning future conferences and CNA's special committee on nursing research for planning assistance.

A limited edition of a full report on the conference and all its papers will be published in the spring. Copies will be available on loan through the CNA Library in the same way as proceedings of other nursing research conferences.

CNA members are invited to submit resolutions for presentation at the Annual Meeting and Convention, June 1976.

Resolutions must be signed by two CNA members and forwarded to the Resolutions Committee, CNA House by 12 February 1976.



The Marjorie Hiscott Keyes medal was presented last October to Dean Armstrong of Vancouver by Eric Morris; national treasurer of the Canadian Mental Health Association. (CMHA) The annual CMHA nursing award is in recognition of outstanding psychiatric services to the mentally ill. Armstrong is head nurse on the psychiatric unit of Lions Gate Hospital in North Vancouver.

NUA Course Expands to Foreign Countries

Canada's only national inservice educational program for nurses, the Extension Course in Nursing Unit Administration (NUA), now in its tenth year of operation, has enrolled a total of 659 students for the 1975-1976 academic year. Almost three-quarters (72%) of these students are married; 43 are men; and the average age of the students is 35 years. A total of 356 hospitals are represented in this year's program. Highlights of NUA activities were brought out at the most recent meeting of the Canadian Nurses' Association/Canadian Hospital Association Joint Committee that administers the program.

The NUA program came into being as a result of a brief presented by a Joint Committee of the Canadian Nurses' Association and the Canadian Hospital Association to the W.K. Kellogg Foundation requesting financial support for a continuing educational program for head nurses.

Requests from ministries of health outside Canada have resulted in implementation of the programs in Lebanon and the Republics of Zaire and Haiti. These projects receive financial support from the Canadian International Development Association (non-governmental organizations).

Violence in Lebanon, where the first overseas workshop was held, prevented completion of last year's session and has forced postponement of the 1975-76 classes. In Zaire, 15 students have been accepted this year. They attended an initial session in Kinshasa in September. Five students have also been accepted for a similar program now getting underway in Haiti.

The Extension course is an inservice type of program planned to help nurses in supervisory positions improve their skills in the management of the nursing unit. It is directed towards those who are unable to attend a university school of nursing. The program is conducted by combining home study and workshop methods.

Information and application forms are available from Dorothy Nelson, Director, Extension Course in Nursing Unit Administration, 25 Imperial Street, Toronto, M5P 1C1.

Wanted: A Caring Heart and Warm Hands

"Death is not the enemy — inhumanity is. I want you to go back to your hospitals and seek out the enemy." Joy Ufema, internationally known for her work with dying patients, was speaking to participants in a clinical day sponsored by the Royal Ottawa Hospital in Ottawa last November.

"A caring heart and warm hands" are the criteria for her job, according to the Philadelphia-based registered nurse. Ufema explained that she did not promote any one set approach for dealing with dying people but, in fact, stressed the individuality of the person and *his right to die his own way.*

"I haven't had any experience in actually dying so — anything goes," she explained. She added that she frequently cries with the patient, and that she doesn't offer any information the patient has not asked for. "I too must die," she said and "some days I don't want to do that."

Another speaker, Joy Rodgers, told the participants that "we are now married for a longer time, we invest a lot in one person, we no longer live as an extended family, and therefore, we put our emotional eggs in few baskets. The traditions that once helped us cope have been stripped away." Rodgers, a nurse consultant with the Clarke Institute of Psychiatry in Toronto, works with bereaved people, particularly widows. Problems of mental health, sleeping, and menstruation are just some of the risks of bereavement she said.

Bereaved people, of which there are 470,000 annually in Canada can display anything from headaches and dizziness to increased alcohol consumption and suicide; these people need to believe that their feelings are normal and that you will accept them and listen, she explained. Rodgers stressed that feelings of anger and guilt cause the most difficulty and that these feelings need to be expressed verbally. "Our program," Rodgers said, "has found that other widows who have adjusted are the most helpful to the recently bereaved." We are hoping to offer our services to the community in the near future, she concluded.

Dr. Ina Ajemian of the Royal Victoria Hospital in Montreal told participants how the "palliative unit" at that hospital came to be established. "Patients who are terminally ill are sent to this unit, and we help them maintain their dignity, listen to them, offer companionship and help them control their symptoms," she said. She explained that visitors are welcome anytime and that even pets are allowed. Dr. Ajemian described the home care program and how it maintains the patients at home and decreases the amount of time needed in hospital.

Assistant Editor

The Canadian Nurse, a monthly journal published by the Canadian Nurses' Association, needs an Assistant Editor.

Requirements: R.N. and member of provincial nurses' association; bachelor's degree in nursing, journalism, general science, or arts; recent clinical experience; experience and/or interest in writing and editing; and willingness to travel.

Location: Ottawa

Qualified applicants are invited to send their complete resume to: The Editor, The Canadian Nurse, 50 The Driveway, Ottawa, K2P 1E2.

Tough Luck!

The New Brunswick Association of Registered Nurses was one of 85 Atlantic province organizations invited by the Prime Minister's Office to attend a special meeting called to explain the Government's anti-inflation program. Glenna Rowsell, employment relations officer for the Provincial Collective Bargaining Councils, represented the association at the meeting held in Halifax November 14.

In response to concern expressed by Rowsell regarding the effect of wage controls on New Brunswick nurses, the prime minister replied that it was "tough luck" they were behind the rest of Canada in wages. Rowsell pointed out that the concern was the relatively low salaries received by New Brunswick nurses compared to those in other Atlantic provinces.

The Prime Minister's response angered many observers at the meeting, especially when he referred to N.B. nurses' wages as being historically behind Ontario and the rest of Canada.

Mr. Trudeau later softened his stand and said that perhaps New Brunswick nurses could seek exemption from the 10 percent ceiling before the Government's Anti-Inflation Board.

News

Cooperation Needed Between Mental Health Groups

Volunteer, government and professional groups for care of the mentally ill have proliferated, but unless there is cooperation between them there is danger that care will be fragmented and incomplete, warns George Rohn, general director of Mental Health/Canada. The failure of the "piecemeal approach" was the reason for the Canadian Mental Health Association's three-year effort, Community Action for Troubled People, now in its second stage.

"We have found that informal cooperative agreements do not work either," Mr. Rohn said at the association's annual meeting, Partnership Action for Troubled People, in Vancouver 23-25 October. He pointed out that everyone gives lip service to the idea of cooperation, but no one seems concerned with how to make it work. "Now is the time to work out more formal agreements, perhaps contracts, certainly negotiated agreements," the general director said in his opening comments.

The three-day meeting was attended by 489 delegates from all parts of Canada. About 65-70 percent came from CMHA's 170 local branches across the country, according to Lance Hale of Mental Health/Nova Scotia. The remainder were invited delegates from professional groups and government agencies.

"Our aim is to discover, through the workshop groups, *how* to make partnerships happen and how to make them work," he said in an interview.

Although most of the work was done in small workshop groups where ideas for implementation into community programs were hammered out, the delegates also assembled to hear panels of speakers provide overviews on the problems.

Keynote speaker was Pat MacKay of Toronto, president of the Canadian Council on Children and Youth, who said lack of agreement on priorities was a major problem behind disagreements between groups supposedly working toward one goal. She said fragmentation occurs because some groups are concerned only with treatment and others only with prevention when both are vital.

Huguette Labelle, principal nursing officer with the federal department of health and president of the Canadian Nurses' Association, was one of the speakers discussing ways to obtain needed community services. She stressed the importance of looking for cures rather than treatment for obvious signs of trouble.

"Is it really the answer to add extra policemen in a small community when there is a sudden increase in juvenile delinquency?" she asked.

Ms. Labelle stressed that the health professional is essential and must assume a greater role as "a community analyst, an organizer, an activator and a provider of service."

Dr. Richard Foulkes, director of the BC government's health security programs, was the most critical of the speakers, saying, "If we talk only about organizing, reorganizing and reshuffling, we will be wasting our time. Change does not come from the top of an organization, which is dedicated to maintaining the status as it is. The creation of social change is at the bottom, at the neighborhood level," he said.

Jean Lupien, new deputy minister of the federal department of health, said he is concerned that the federal government must take a greater leadership role. He promised more support for mental health programs.

Nurse-Midwives in Health Care System

Nurses involved in obstetrical care, some of whom are midwives, met at Memorial University, St. Johns, Newfoundland last Fall to form the Atlantic Nurse-Midwives Association. They drew up a constitution and objectives of the Association. Their main objective will be to improve maternal and child care throughout the Atlantic provinces.

The Atlantic Association hopes that members of the Western Association will meet with them during the CNA Convention in Halifax in June. Further information can be obtained by writing to: Lynda MacDonald, Dalhousie University, School of Nursing, Halifax, N.S.

A Canadian National Committee of Nurse-Midwives was organized in June, 1974, during the last CNA convention in Winnipeg. The group provides a communication link between regional associations of midwives and related health organizations. Canada was admitted to the International Congress of Midwives in July 1975.

What is the midwife's role?

An answer to this queston was published recently in the newsletter of the Alberta Association of Registered Nurses:

The well-being of the mother and child is the goal of all members of the International Confederation of Midwives. According to Pat Hayes, president of the Western Nurse Midwives' Association, the midwife's role differs from one country to another, being dependent on the socio-economic levels, the type of health care delivery system and the general and professional education system.

In many countries nursing is not a requirement for midwifery practice and midwives are considered independent professionals. The length of their education equals or exceeds that of nursing. Although traditional midwives are still employed in a few countries their education is constantly being improved.

Countries such as Canada, the United States, New Zealand and Australia consider midwives to be highly specialized nurses. In effect the midwives' role is a development of the traditions of maternity care prevalent in each country.

If the practice of midwifery rested solely on the process of delivering the baby it is doubtful whether midwives would be acceptable in Canada. But delivery is a small part of a spectrum of care which stretches from conception to the termination of the postpartum period. Midwives can be responsible for prenatal counselling, education, and continuity of care. Their expertise is of value in care of the mother in labor and in supervising the mother as she learns how to care for her new baby, as Canadian midwives are now doing.

Many perceive the midwives' role as part of the tradition of domiciliary practice. But in countries such as England, Switzerland, New Zealand and Australia there is an increasing trend towards hospital continements and a system similar to that in Canada. A team approach is being advocated each professional bringing to the team unique skills and knowledge which, through a colleagual relationship, enables maternity care to be optimized.

Canada's association with I.C.M. will enable nurses in this country to learn from others and, also, to give information to others as well.

Regional Trauma Centre

Nurses will be members of a trauma resuscitation team established for the management of the critically ill at Sunnybrook Medical Centre. The trauma team notified in advance, will be prepared to treat the patient as soon as he arrives. Surgeons, anesthetists, and nurses will constitute the resuscitation team — just one part of the new regional trauma centre at Sunnybrook.

Dr. Robert McMurtry, director of Emergency Services, in a telephone interview, said that "all Emergency staff will be involved in educational programs, to update and refresh their knowledge on the management of trauma. Nursing will be involved in the decision-making process in the unit, and a nursing committee has been established. ."

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The 1975 index for *The Canadian Nurse*, vol. 71, is available on request. Write to *The Canadian Nurse*, 50 The Driveway, Ottawa, Ontario, K2P 1E2.

News

ONQ Publishes List of Nursing Procedures

A nonrestrictive list of nursing procedures that nurses are allowed to perform without a medical order has been published as a result of the Order of Nurses' of Quebec's annual meeting last November. The document also indicates the slight difference that exists between an authorized medical act and a nursing procedure performed under a medical order. It does not, however, deal with the independent functions of the nurse.

According to the ONQ, the decision to administer a nursing procedure is a medical act, but the performance itself pertains to nursing. Therefore, doctor's orders should not be required for these nursing procedures and authorization should be required only for the performance of certain procedures under particular circumstances.

Negotiations between the Professional Corporation of Physicians and the ONQ have now terminated without agreement on the definition of acts or procedures to be authorized. According to the ONQ, doctors generally believe that nursing is an extension of medicine; therefore they are convinced that they must grant nurses the authorization to perform nursing procedures. If nursing procedures were medical acts, then doctors would have to assume the training and control of the persons who perform these procedures. Procedures such as catheterization are not *medical acts*, but rather *nursing procedures* performed under a medical order. Jeannine Tellier-Cormier, president of ONQ, points out that the rules adopted by the medical profession and released by the Quebec Professions Board in October do not take into consideration the nurse's position.

At the annual general meeting of the ONQ in November, the general assembly recommended that: information about nursing as a career and an outline of educational requirements be made available to chapters, schools, and counselors; consideration be given to the possibility and praticality of requiring continuing education as a requirement for renewal of licensure; and CNA consider changing the name of the magazine *L'infirmière canadienne* to take into account the increasing number of male nurses within the profession.

In addition to research projects concerned with the definition of nursing, the Order plans to intensify its information program on the role of the nurse for the general public.

B.C. Nurses Seek Better Care For Elderly

Expansion and improvement of British Columbia's facilities for the care of the elderly are being sought by the Registered Nurses' Association of B.C.

In a statement to the provincial government and all opposition parties, the association has urged an end to the present "poor utilization of beds and the inhumane way we shuffle people from one institution to another."

The Association calls for improved criteria for the admission of the elderly to longterm facilities; for the introduction of regional multi-disciplinary assessment teams to apply these criteria; for the expansion of home-care services; for the redesignation of longterm care beds to prevent "gross people upheaval"; and for greater attempts to meet the personal care needs of the elderly.

The statement also notes that:

— present criteria make no allowances for psychosocial needs, age, prognosis, institutional limitations or the fact "that the commodity being assessed is elderly human beings."

— there are not enough institutional beds available in most areas.

— home-care services are inadequate.

The statement was developed by the Greater Victoria District of the RNABC and adopted by the provincial board of directors.



Studio C. Marcil, Ottawa, Ontario.

CNA has added another example of local craftsmanship to its display of gifts from member-provinces. A distinctive pewter wall hanging, entitled "Fiddlehead Sunrise," was given to the Association by the New Brunswick Association of Registered Nurses.

The three-dimensional plaque was designed and executed by Carole Cronkhite, a Fredericton artist. It depicts the sun rising in the east, along with a fiddlehead motif. (Fiddleheads are an early growth of Ostrich Fern considered a gourmet delicacy.) The wall hanging shown above with NBARN executive secretary Jean Anderson (right) and CNA president Huguette Labelle, is on display in the main entrance lobby of CNA House. A ceramic planter that was a recent gift from the Alberta Association of Registered Nurses is also suspended nearby.

Canadian Diabetic Association Sponsors Bursaries

One of the two Ames Bursaries for 1975 has been won by Mavis Verronneau, diabetic teaching nurse at the Montreal General Hospital in Montreal. Her project involves preparation of a diabetic teaching manual in both English and French.

Two bursaries of up to $1,000 each are offered annually by the Ames Company, a division of Miles Laboratories Limited. Application forms are available from the Canadian Diabetic Association, 1491 Yonge Street, Toronto, Ontario. Deadline for submission of protocols to this Association is March 1, 1976.

Association Offers Legal Aid to B.C. Nurses

British Columbia nurses not covered by collective agreements can now apply for RNABC legal aid to help resolve serious disputes with their employers.

Under a system approved recently by the association's board of directors, members excluded from bargaining units may obtain loans to retain lawyers, if legal action is considered necessary to settle disputes.

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Calendar

February 5-6, 1976
"Nursing and the Adolescent" to be in Vancouver. *Contact: Continuing Education in Health Sciences, University of British Columbia, Vancouver, B.C., V6T 1W5. Phone: 228-3055.*

February 27-28, 1976
Conference for Recovery Room Nurses, in Vancouver. Contact: Continuing Education in Health Sciences, University of British Columbia, Vancouver, B.C., V6T 1W5.

March 8-12, 1976
Gerontological nursing workshop to be held at Toronto hospitals. For information, write: Dorothy Brooks, Chairman, Continuing Education Program, University of Toronto Faculty of Nursing, 50 St. George Street, Toronto, Ontario, M5S 1A1.

March 11-12, 1976
Seminar "Conflicts in the Physical Rehabilitation Team" to be held in Ottawa (was to be in January). *For information, contact: Carolyn Belzile, Coordinator, Continuing Education Program, School of Health Administration, University of Ottawa, Ottawa, Ontario. Telephone: 231-5062.*

March 11-12, 1976
"Nursing Care in the Postpartum Period" to be in Vancouver. *Contact: Continuing Education in Health Sciences, University of British Columbia, Vancouver, B.C. V6T 1W5.*

March 17-18, 1976
"Optimum Cardiac Rehabilitation" to be held in Vancouver. *Contact: Continuing Education in Health Sciences, University of British Columbia, Vancouver, B.C. V6T 1W5.*

March 18, 1976
"Stress — Coping with it in Nursing" to be in Calgary. *Contact: Division of Continuing Education, University of Calgary, Calgary, Alberta, T2N 1N4.*

March 23-25, 1976
"Role of the Nurse Administrator in Staff Evaluation Programs" in Vancouver, for supervisory personnel. *Contact: Continuing Education in Health Sciences, University of British Columbia, Vancouver, B.C. V6T 1W5.*

April 5-6, 1976
"Being Old and Human Too — Implications for Nursing" to be in Calgary. *Contact: Division of Continuing Education, University of Calgary, Calgary, Alberta T2N 1N4.*

April 21-23, 1976
Pediatric Intensive Care Nursing Conference at the Hospital for Sick Children, Toronto, Ontario. *Information from: Hilda Rolstin, Nursing Education Department, Hospital for Sick Children, 555 University Avenue, Toronto, Ontario, M5G 1X8. (Phone) 1-416-597-1500 ext. 1517.*

April 26-30, 1976
British Columbia Operating Room Nurses Group fifth biennial institute to be held at the Hotel Vancouver, Vancouver, B.C. *For information, write: Ellen Schrodt, 103-930 Glenacres Drive, Richmond, B.C., V7A 1Y8.*

May 16-19, 1976
American Lung Association — American Thoracic Society annual meeting to be held in New Orleans, La. For information, write: Chairperson, Annual Meeting Nursing Program Subcommittee, American Lung Association Nursing Department, National League for Nursing, 10 Columbus Circle, New York, N.Y., 10019, U.S.A.

May 24-28, 1976
International Ophthalmic Study Courses for nurses to be held at Wolverhampton and Midland Counties Eye Infirmary. *For information, write: the Secretary, Wolverhampton & Midland Counties Eye Infirmary, Compton Road, Wolverhampton WV3 9Q4, England.*

May 28-June 1, 1976
Annual convention of the American Society of Adlerian Psychology to be held at the University of British Columbia, Totem Park Convention Centre, Vancouver. *For information, write: Edna Nash, BCAAP, P.O. Box 33823, Station D, Vancouver, B.C., V6L 4L6.*

June 6-11, 1976
American Nurses' Association Biennial Convention in Atlantic City, N.J. For information, write: Convention Unit, ANA, 2420 Pershing Road, Kansas City, Missouri 64108.

June 7-10, 1976
Canadian Conference on Youth, Society, and the Law, sponsored by the Canadian Criminology and Corrections Association, is to be held at Queen's University, Kingston, Ontario. *For information, write: Chairman, Canadian Conference on Youth, Society, and the Law, 55 Parkdale Avenue, Ottawa, Ontario, K1Y 1E5.*

June 13-17, 1976
Biennial Canadian conference on social welfare to be held at Skyline Hotel, Toronto, Ontario. Sponsored by the Canadian Council on Social Development. *For information, write: Reuben C. Baetz, Executive Director, CCSD, Box 3505, Station C, Ottawa, Ontario K1Y 4G1.*

June 16-18, 21-23, or 24-26, 1976
Regional conferences cosponsored by the Registered Nurses' Association of Ontario and the Ontario Hospital Association will be held June 16-18 at New Parkway Hotel, Cornwall; June 21-23 at Laurentian University, Sudbury; June 24-26 at Ontario Hospital Association, Toronto. *For information, write, Eleanor Trutwin, Professional Development, RNAO, 33 Price Street, Toronto, Ontario, M4W 1Z2.*

June 21-23, 1976
Annual meeting of the Canadian Tuberculosis and Respiratory Disease Association will be held at the Regency-Hyatt Hotel, Vancouver, B.C. The Nurses' Institute and the Canadian Thoracic Society's scientific sessions are held at that time. *For information, write: CTRDA, 345 O'Connor Street, Ottawa, Ontario, K2P 1V9.*

June 21-23, 1976
Canadian Nurses' Association annual meeting and convention to be held at Hotel Nova Scotian, Halifax, Nova Scotia. Theme: The Quality of Life.

June 22-25, 1976
Canadian Public Health Association annual meeting to be held in Moncton, New Brunswick. *For details, write: CPHA, 55 Parkdale, Ottawa, Ont., K1Y 1E5.*

July 23-25, 1976
Kingston Psychiatric Hospital Nurses' Alumnae Association Reunion '76. *For information, write the general convenor, N.R. Ferguson, 312 College Street, Kingston, Ontario, K7L 4M4.*

July 25-30, 1976
Tenth Biennial Conference of the Caribbean Nurses' Organization will be held in Barbados, West Indies. *For information, write: Caribbean Nurses' Organization, P.O. Box 2018, Curacao, Netherlands Antilles.*

August 29-September 3, 1976
Ninth International Conference on Health Education will be held at the Skyline Hotel, Ottawa, Ontario. Theme: "Health Education and Health Policy in the Dynamics of Development." *For information, write: Canada's Organizing Committee, Ninth International Conference on Health Education, c/o CHESS, P.O. Box 2305, Station D., Ottawa, Ontario, K1P 5K0.*

October 28-31, 1976
International Congress of Sexology, cosponsored by the Department of Sexology of the University of Quebec in Montreal and the Society for the Scientific Study of Sex, to be held at the Sheraton-Mount Royal Hotel in Montreal. *For information, write: Prof. Robert Gemme, Department of Sexology, University of Quebec in Montreal, P.O. Box 8888, Montreal, Quebec, H3C 3P8.*

June 19-25, 1977
International congress of the World Federation of Neurosurgical Nurses to be held in Sao Paulo, Brazil, in conjunction with the 6th international congress of neurological surgeons of the World Federation of Neurosurgical Societies. *For information, write: Rosanne Mazzola, Secretary, WFNN, 277 Forest Avenue, Paramus, N.J. 07652, U.S.A.*



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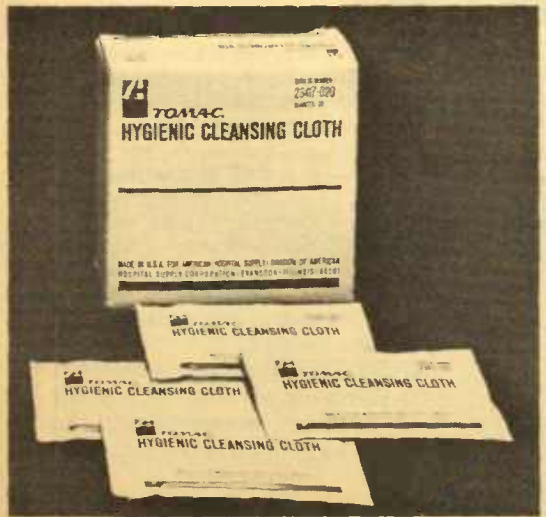
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"The quality of life," a concern of most contemporary North Americans, has been chosen as the theme of the 1976 Annual Meeting and Convention of the Canadian Nurses' Association, to be held at the Hotel Nova Scotian in Halifax, June 20-23.

The Program Planning Committee has gone to great lengths to create a dynamic and innovative program that is in keeping with the needs of today's nurses. Although not all the names of speakers and participants had been finalized at press time, a general outline was available.

During the opening ceremony on Sunday evening, June 20, international, national, provincial and local representatives will welcome delegates. The name of the guest speaker will be announced in *The Canadian Nurse* at a later date.

A keynote speaker of international stature will lead off the professional program on Monday morning June 21. A discussion period will follow.

In the afternoon a debate is scheduled on the question: "Resolved that nurses have a responsibility to take action to preserve life in the event of any decision by a patient, a family, or a professional to discontinue artificial life-maintaining intervention." Apolline Robichaud, director, Public Health Nursing, Department of Health, Fredericton, N.B. and past president of the NBARN from 1971-73, will chair the debate.. Following the debate, an interview dealing with the impact of the nursing profession on the quality of life will take place. Patrick Watson, well-known television personality, will interview Shirley Post. Post is presently conducting a study on the need for a Canadian Institute of Child Health.

Tuesday, June 22, will be devoted to affairs of your national association; a schedule will be published at a later date. On Wednesday, June 23, delegates will focus on the quality of life in the work world of the nurse. This will take the form of two sessions: the first, a panel composed of four participants who will present short papers on the following subjects: 1) the incompatibility between educational preparation and the practice setting; 2) uncertainty regarding the nurse's legal protection; 3) enforced proximity to stress in the client environment; 4) social and economic pressures in the work environment of the nurse.



The second session entitled "You and the quality of life— action for today" will be presented as an audiovisual event intended to challenge nurses to try to improve the quality of their own lives and that of their clients.

The final afternoon will be reserved for discussion of the report of the Resolutions Committee, the installation of officers and the president's reception.

Interest session on research

An interest session planned by CNA's Special Committee on Nursing Research will be held Thursday morning June 24, following the convention. This session, entitled "Did you ever wonder what would happen if ....?" will take the form of a round table discussion of research questions and answers. Beverlee Ann Cox, nursing consultant with the Department of Psychiatry and lecturer in the School of Nursing at the University of British Columbia, has accepted the chairmanship of the session. All interested members are welcome.

Special interest groups interested in holding a meeting on the Thursday or Friday following the convention are invited to contact Hallie Sloan, nursing coordinator at CNA, as soon as possible.

CNF annual meeting

The annual meeting of the Canadian Nurses' Foundation will be held on Sunday June 20, from 14h to 17h, at the Hotel Nova Scotian.

Next month: Social program and tourist attractions.

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P.S. OH YES, WE ARE OPEN EVENINGS

This month's forum has been submitted by CNA member-at-large for nursing education, Shirley M. Stinson, professor, School of Nursing, and Division of Health Services Administration, University of Alberta, Edmonton.

Frankly Speaking about nursing education

National and/or Regional Centers for Preparing Nursing Educators

Shirley M. Stinson

In a current survey "The Teaching of Health Sciences in Canadian Universities," the authors, Bryans and Southall, raise the question, "Should there be national and/or regional centers for the preparation of health sciences teachers?" I would like you to consider this question from two perspectives: advantages and disadvantages to the health sciences in general and to nursing in particular.

General Advantages:

Potentially better utilization of "rare" faculty and complex A-V/library resources, plus the added advantage of developing in one or more centers a critical mass of related specialists; students could be exposed to a wide range of health science students and faculty; interdisciplinary research projects could be a concommittant development; economies of scale in the teaching of "core" content in such areas as curriculum development, health services research principles; centers might attract educational funds not otherwise available on a single institutional basis; centers could encourage large scale evaluative research of health sciences teacher preparation programs; further, if health sciences teachers were prepared together in an interdisciplinary setting, perhaps they would subsequently be capable of higher levels of interdisciplinary teaching in their home institutions.

General Disadvantages:

Even if many students are free to move to another city, to what extent is sheer proximity to programs a factor in teacher training recruitment? Relocation would obviate "part-time" student provisions for other than residents in the areas in which the centers were located; to the extent that a substantial number of faculty in such centers would be drawn from those currently employed in various education and health sciences faculties across Canada, there could be a serious debilitating effect on the home universities; adequate clinical facilities for both teaching and research in a center of any consequence would likely be a problem in any location in Canada; there is the possibility of "lack of hybrid vigor" if teacher training in the health sciences gets too standardized, too monolothic in its norms and policy control mechanisms; perhaps over time and through fairly large scale "bureaucratization" of teacher training, lack of responsiveness to new teaching/learning needs could develop in large centers.

There would also seem to be some advantages and disadvantages somewhat unique to nursing:

Advantages for Nursing:

It is possible that nursing might not be able to generate on its own the sociopolitical thrust necessary to get such centers in operation, and it could be an advantage to be able to "ride the wave" of such an innovation. In so doing, nursing could conceivably obtain a magnitude and quality of nursing teacher preparation beyond the scope of any one school of nursing at this point in time. Further, the preparation of nursing educators could be carried out within an interdisciplinary health sciences context, a factor consistent with the learning and practice needs of today's nursing educators.

The major disadvantages are few in number but important for their possible consequences:

Disadvantages for Nursing:

Approximately 60 percent of employed nurses in Canada are married. Many of these are logical candidates for teacher preparation. This constitutes perhaps the most crucial disadvantage of all, since the majority of these candidates have home commitments that would not permit them to relocate in other cities, even temporarily, in order to enrol in teacher preparation programs.

A little less than half of university nursing faculty have masters' or higher degrees; and only 300 of the approximately 2,500 teachers in the total nursing teacher situation (i.e. university, hospital and college division programs), about 12 percent, are qualified beyond the baccalaureate level. In short, the number of faculty requiring graduate level preparation is so large that it can reasonably be argued that setting up a few centers would not effectively change this situation.

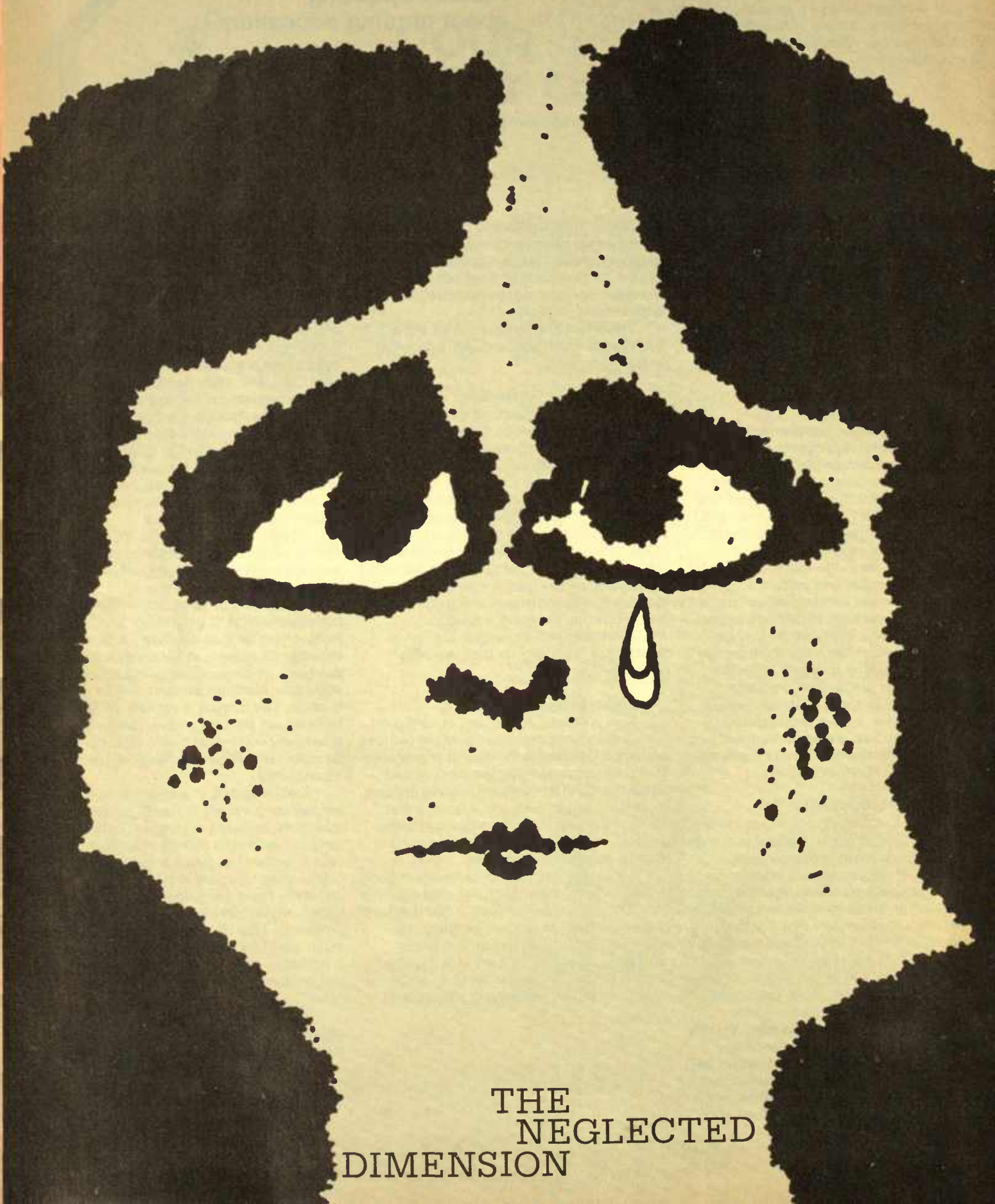
On the other hand, it can be argued that, in contrast to other health disciplines, most nurses with even one year of university preparation, about 72 percent of the total, and 97 percent of university nursing faculty) do have some preparation in teaching-learning principles, and many nursing faculty have specific preparation in curriculum development. Indeed, it might well be argued that the need for centers which offer advanced substantive preparation in nursing practice and related biosocial sciences is as great if not greater than the need for teacher preparation centers. The crux is to have something valuable to teach.

There is another factor to be considered. On the basis of well-established occupational sociological principles (not feminism!), it can reasonably be predicted that in multidisciplinary settings "lower status" professions tend to get shorter shrift than those of higher status. Since it took several decades for nursing to establish relative autonomy in determining its educational standards, nursing educators may be reluctant to participate in such a venture. Medical faculties, on the other hand, (which have historically dominated health sciences faculties) are unlikely to have the same reservations.

Assuming that, in addition to educational specialists, a variety of health sciences educators, including nursing educators, would be attracted to such centers, the effect of even one or two well-qualified nursing teachers and/or nursing deans leaving any one university could be quite catastrophic, particularly for universities with graduate programs. This state of affairs in itself says much about the crisis in nursing teacher preparation in Canada today: *we do not have enough teachers to prepare the teachers we need.*

Should there be national and/or regional centers for the preparation of nursing teachers? What do *you* think?

Crying



THE NEGLECTED DIMENSION

The authors attempt to delve into an unexplored dimension . . . crying, so that nurses as members of the "helping profession" can do more for people who need to cry than just "give them privacy."

Abigail McGreevy

Judy Van Heukelem

Crying is a phenomenon familiar to all of us. Although our degree of comfort in its presence varies greatly, crying is a part of life. It is an essential participant in the delivery of the neonate, and a companion in the grieving process. Crying can also be a constructive way of releasing tension. The fact remains, that, for the majority of nurses, the crying patient represents a difficult problem. Most of us tend to avoid this situation or to stop the crying immediately at any cost.

The crying syndrome

Crying is a distinctly human activity that takes place in response to emotional stimuli. There are many somatic changes manifested during crying, some of which can be explained physiologically, and others whose explanations are rather unclear. The limbic system, which has an important role in the control of emotional behavior, probably also functions in the crying mechanism. The autonomic nervous system, through the parasympathetic fibers, stimulates lacrimation and nasal secretion. This serves to protect the mucous membranes of the naso-pharynx. Respiratory changes, with extended expiration, are ultimately responsible for reddening of the face and eyes, edema, and eye closure.

Crying in humans, other than infants, occurs under many circumstances, usually in response to unpleasant stimuli. Most writers agree, however, that the effects are beneficial.

Generally, crying seems to be a safety valve, a mechanism for releasing built-up tension or excess energy, — perhaps an internal change taking an attitude of hostile aggression and dissipating its energy in a nondestructive manner.[1]

Whether lacrimation or fluid secretion (the actual tears themselves) during crying is to prevent dehydration and subsequent damage to nasal mucous membranes[2] or a physiological local defence with healing, nourishing and soothing functions for the eye[3] is open to question. These are just two of the theories regarding the reason for the tears.

It does appear that after crying, a feeling of relief and relaxation seems to be prominent. This is a consistent theme to most studies of the subject. A general result of weeping seems to be a feeling of relief, a calmer frame of mind and possibly a desire for rest and sleep.[4] Some studies even claim to have observed that many forms of illness show tendencies towards recovery after crying.[5]

For these reasons, there may be occasions when we want to encourage it, both in our patients and ourselves.

Unfortunately, therapeutic crying is not found on the curriculae of most nursing schools. We do not know how to encourage crying when it may be physically, emotionally or spiritually beneficial.

The threshold for crying, or point at which emotions can be stacked no higher (the emotional straw that broke the camel's back, so to speak), varies not only from individual to individual, but from one level to another within each person, depending on circumstances. Sex, age, cultural background and experience with crying differentiate the threshold between individuals. Within individuals, the threshold may be raised or lowered depending on suggestion (situation, environment, such as a sad book or movie); privacy, or lack of it; acceptability, both stated and implied to others present and as perceived of oneself; and energy level, or general health. The degree of activity of the mind also has an effect as absorption in an energy-consuming activity would either dissipate the emotion that was to have been cried away, or at least defer concentration on it while the mind was otherwise occupied.

Table one provides some examples of how these factors have the effect of raising and lowering the threshold of crying.

Table one — Factors in threshold variance

Between Individuals

	Raises threshold	**Lowers threshold**
Culture	example — Indian culture expect stoical approach	example — weeping expected in Italian culture
Past history	father poked fun of daughter's crying	mother expressed emotions freely and cried at times in front of family
Sex	generally in males crying less acceptable	crying equated often with dependence and more acceptable for females
Age	adolescents & adults expected to cry less easily	children & perhaps aged are allowed to cry much more frequently

Within an Individual

	Raises threshold	**Lowers threshold**
Energy available	absorption in a task (energy being diverted)	tired
		ill
	rested and in good nutritional state (able to control self)	hungry
Social situation	being in a social situation where Individual is "in charge"	being alone
	being with people individual isn't comfortable with	being with people or person who accept individual
Expectations of Others	crying means loss of esteem	permission implied or stated
	permission denied by statement or implication	suggestion, as in seeing others cry

Relating to crying

HELP WANTED:

Professional nurses, comfortable enough with self to deal constructively with crying patient. Inquire within.

Crying is only one of several ways the mind and body deal with frustration, and when these other conventional ways are not available to us or have been unsuccessful, crying can constructively relieve tension. There is an element of truth in the adage that "tears come when words can't."

Perhaps if we tried to answer for ourselves four pertinent questions, the discovery of a crying patient would cease to be the troublesome dilemma most nurses consider it to be. These questions which might help put crying in perspective, are:

How do I react to my own crying?
What effect does someone else's crying have on me?
What are the specific needs that crying expresses?
What constructive action can I take?

- *How do I react to my own crying?*

Many people are uncomfortable expressing their frustrated feelings through crying; it makes them feel guilty, weak, helpless, or silly. In nursing education, the idea that crying is silly and unproductive is often either stated or implied.

Crying is considered "unprofessional." As a result, the nurse has even more trouble crying than most people because she feels her professional identity is at stake. Before she can be comfortable with a crying patient, the nurse has to learn to accept her own occasional need to cry as an acceptable response for dealing with feelings.

- *What effect does someone else's crying have on me?*

Crying by another person can hold many different meanings for each of us. Some of the more common feelings, meanings and resulting actions or reactions are outlined below in chart form. It is not assumed that this is exactly what happens. These are just some of the results that might be seen when a helping person comes into contact with a crying person.

This list is by no means exhaustive, but is designed to help you get in touch with your own feelings. Perhaps this would be a good time to stop and consider what your own personal reaction is to crying. Use the accompanying table. Look into yourself and determine how crying makes you feel, what meaning it has for you and what your typical reactions to crying have been. When you have dealt with your own feelings, then you are ready to think of the patient as an individual and work with him.

- *What are the specific needs that crying expresses?*

If crying is an expression of our frustration at failure to meet some of our needs, then a nurse's understanding of these needs, both physical, spiritual or emotional, of what an individual's crying represents to him or her, is obviously vital to dealing constructively with this person.

The danger lies in assuming too quickly that we know why a patient is crying, or in projecting our own feelings and needs onto the crying individual. It is well to remember that physical, spiritual or emotional distress can bring about a lowering of self-esteem, resulting in an inability to handle situations adequately.

Physical needs

Pain or physical distress is an obvious cause for crying, most often seen in our culture in children. Acute pain can lead to crying in adults as well, perhaps because it leads to loss of control.

The woman who has an abcessed tooth, has lost the ability to chew and is aching from head to toe, may break down into tears. The young man with a debilitating case of hepatitis may weep silently into his pillow after a painful injection.

Emotional needs

Any number of emotional needs may be behind a person's crying. We feel, however, there is one which predominates — the need for self-esteem.

The need for self-esteem might be compared to an opened umbrella and its spokes. The umbrella of self-esteem can only stay open when the spokes of emotional needs are fulfilled.

Some of the needs that must be fulfilled in order for the umbrella of self-esteem to expand include: physical comforts; personal warmth; acceptance; a "special" someone we care about and who returns our affection; understanding, both on our part and on the part of others towards us; the need to deal effectively with and to express angry or hostile feelings.

Spiritual needs

Spiritual needs, though probably the last to be recognized and identified, are likely to be expressed in crying. While emotional needs deal with horizontal relationships to self and others, spiritual needs are vertical and directed to a Supreme Being, and involve a person's relationship with his God. Spiritual needs can be defined as "any factors necessary to establish and maintain a person's dynamic, personal relationship with God." . . . There is a basic need for relationship and out of it to find forgiveness, love, hope, trust, and meaning and purpose in life.[6] Because the individual's relationship to his God is a very personal one, and to many people the subject of religion is taboo, crying may be one of the few ways that a spiritual need can be exhibited.

Man is a whole being, not just the sum of his parts. Spiritual needs are often expressed emotionally (feelings of fear, guilt, worthlessness) or physiologically (sighing, restlessness, crying). The loss of one's relationship to God, or a real or perceived lack in this area, can represent a deeply troubling experience and arouse much anxiety. Illness and threat of death have a way of raising questions regarding the ultimate meaning of life. For some, there can be an awareness, never before felt, of a need for "making things right" with God (establishing a relationship with God). For others who have been religious most of their lives, illness, crisis, or impending death can raise serious questions about the goodness of God, the meaning ot suffering, life after death. They may perceive that something has happened to their previous relationship with God. Crying then can express an individual's struggle to deal with his view of God in relation to the present crisis.

- *What constructive action can I take?*

The first thing a nurse can do is to watch for prodromal symptoms of crying, as indicated by: tightly-drawn lips, averted eyes, rapid blinking, eyes filled with tears, an inability to talk, a quiver or "catch" in the voice, sniffling and reaching or looking for a tissue.

On rare occasions crying should be discouraged, for example with an hysterical or overly-manipulative patient.

Generally however, the best course is to encourage crying by lowering the patient's threshold through: suggestion ("You look like you need to cry."); verbal permission ("It's alright to cry," or "Go ahead and let it all out."); non-verbal permission, such as reaching out and touching the patient softly, using a warm tone of voice, presenting a relaxed and unrushed posture by appearing ready to stay and conveying the attitude that "the world has stopped and you have my undivided attention."

Privacy will in most cases also lower the threshold of crying, although this will vary



greatly with the person and the situation. Some patients may need absolute privacy, even from a nurse. If an individual can be moved quickly and smoothly from a crowded or public area to a private one, when the situation warrants it, this needs to be done.

Beware, however, of the person who says he wants to be alone, but who indicates nonverbally that he or she needs to be with someone who understands. If the patient insists on privacy, yet you still feel he or she needs someone, go away for a short time but return.

During

Once crying has begun, it is important to continue a posture of warm acceptance and to stay quietly with the patient. This is not the time to initiate or encourage conversation.

If a tissue can be provided, do so quietly and unobtrusively by tucking it into the palm of

the patient's hand. If you need to get up or leave the room to obtain the tissue, forget it. Large muscle movements will break the mood and the crying threshold will soar. It might be a good idea to always carry a tissue in your pocket for such situations.

After a patient has stopped crying, be available to listen if he or she should wish to talk. A general leading question might be asked ("Is there some way I can help?" or "Would you like to talk about it?"), or a reflective statement made ("Seems like a hard time for you."). Be careful however, not to demand an explanation; there are times when it is impossible to give a reason for tears.

After a long or hard cry puffy eyes, a red face and headache are common. A cold damp cloth can be soothing and reduce swelling. A cup of coffee or tea is often appreciated and the caffeine may decrease the headache caused by dilated vessels. If the headache is severe and persists, it may be necessary to obtain an analgesic.

If possible, provide the individual with privacy by pulling curtains and discouraging visitors. Some patients may need to sleep. They may be tired from the emotional energy spent, while others, for the first time in a while, may be relaxed enough to rest. If the person has to see others, help him wash his face, and if a woman, apply cosmetics. Remember, it is important to help the patient maintain a level of self-esteem.

Often the patient needs to know you have not been burdened by the crying. One way to reassure the individual is to thank him or her for sharing the tears with you. The next meeting after the crying episode may be strained; awkward feelings may exist. It is helpful for both the patient and the nurse to be aware of this; otherwise, either may experience rejection and take it personally.

One of the biggest personal dilemmas a nurse may face is her need to cry along with the individual. It can be assumed that this is acceptable and may be beneficial to both, as long as the nurse's needs do not exceed those of the patient and she maintains a degree of objectivity. Though it is not necessary for the nurse to cry along with the patient, this demonstration of feeling can be a beautiful way to show caring.

When a nurse has gained a new self-awareness concerning her own reactions to crying, she is more apt to understand the needs being expressed by the crying person and consequently, intervene appropriately. Crying can then be a constructive experience for everyone concerned.

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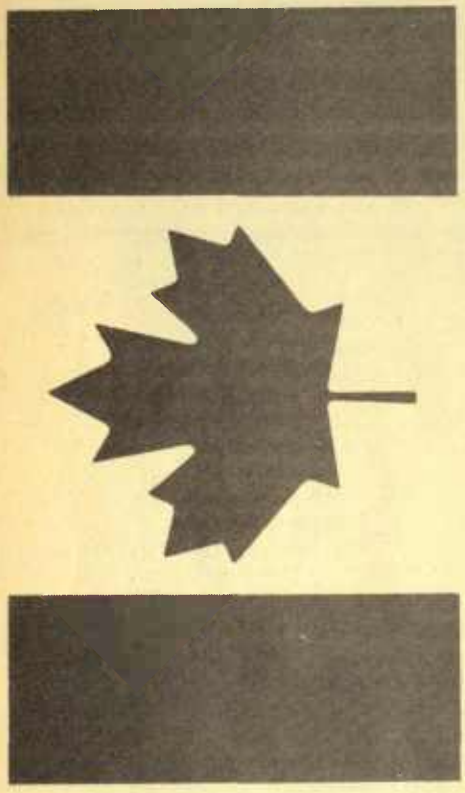
	Feelings	Meanings	Actions/Reactions
A	Helpless Inadequate Frustrated Overwhelmed	"My hands are tied." "There's nothing I can do." "I wish I were God." "I'm incompetent."	Immediate or inappropriate referral Walk, or run, away Depression Freeze; do nothing Change topic Ignore
A	Cruel Mean Rotten	"I could have prevented this." "It must be something I did." "I touched a sore spot." "I made him cry." "I'm no good." "I'm supposed to be relieving pain, not causing it."	Minimize situation: "That wasn't bad, was it?" "It really doesn't hurt that much!" "This is almost over." Reprimand: "You're too old for that."
A	Insensitive	"There's no need to cry."	Ignore Tease Belittle: "Big girls don't cry." "You don't know what pain really is."
A	Manipulated	"I'm not in control." "She's just trying to get her own way."	Frustrated Anger Depressed Avoid Give in
B	Pity	"I feel sorry for you." "You poor thing." "I'll do *anything* for you." "I want to help."	Oversolicitous Loss of professional objectivity False reassurance: "Everything will be all right."
B	Hopeless	"There's no way out." "This situation has to be major or overwhelming."	Avoid Immobilized
B	Concerned	"I care about you."	Listen Stay and help
C	Not aware of any feelings		Walk away Ignore Find more pressing needs

A **Focus: Self**
(My feelings about *me*)

B **Focus: Crying person**
(My feelings about *other person*)

C **Unfocused**

CROSS-CANADA



Registration

Guidance counsellor: "So, you want to be a nurse?" *Prospective student nurse:* "Yes, I want to travel across the country (or around the world) while I earn a living. I want to see new places, to meet new friends, to support myself and see the world at the same time."

The romantic myth of mobility has traditionally provided nursing with a special aura that attracts the footloose and fancy free. None of us today is gullible enough to believe that all we need to do to obtain work as a registered nurse in another province is to answer an advertisement offering employment to RN's and then report to the institution's director of nursing. We know that employers require an applicant to be registered with that province's registering/licensing body. What we tend to be somewhat hazy about, are the precise details about how to accomplish this transfer of registration from one authority to another. Who is eligible? How long does it take? Where do I start? What does it cost? It is to provide answers to some of these questions that this article is written.



What is registration?

Nursing registration is the process by which a graduate nurse has her name entered in the nurses' registry maintained by the professional nurses' association, college, or order in that province, and is authorized to practice as a Registered Nurse (RN).

Licensure is the process by which a graduate nurse is given a permit to practice nursing by the provincial or territorial nursing authority; registration follows automatically.

In Newfoundland, Prince Edward Island, Quebec and the Northwest Territories licensure/ registration is mandatory; that is, nurses must hold a provincial license and be registered as members of a provincial nursing organization in order to practice. In the other provinces, licensure does not exist and registration is not required by law. This means it is legally possible to work as a "graduate nurse," but job opportunities at that level are scarce and salaries are lower.

Who is eligible?

What are the requirements?

The Canadian nurse who wishes to obtain employment as a "Registered Nurse" in a jurisdiction other than the one where she received her nursing education or where she is currently employed must register with the nursing authorities of the province where she intends to work (see table one).

At first glance, one would expect the registration /licensure process to be fairly simple (which it can be) since we are dealing with provinces within the same country. But, since Canada is a federation of ten provinces, each responsible for its own education and health services, requirements and procedures for registration/ licensure vary slightly from one province to another.

Many nurses seem to think that success in writing CNA examinations automatically confers on them the right to register and work anywhere in Canada. This is not the case: applicants must also comply with various provincial requirements before they can obtain employment as an RN in a particular jurisdiction.

Generally speaking, candidates for registration/ licensure must meet the following requirements:

- show evidence of registration with the registering body of the province where they completed a recognized program in general nursing;
- prove that they are currently registered or eligible for registration in that province or the province of last employment;
- demonstrate that they have successfully written the Canadian Nurses' Association Testing Service or National League for Nursing registration examinations in medical, surgical,obstetrical, pediatric and in some cases, psychiatric nursing (a pass mark of 325 or 350 is required);
- show evidence of competency in the practice of nursing, usually through reference from previous employers.
- demonstrate fluency in speaking and understanding the official language of the province.

In Ontario, Quebec, and New Brunswick, either English or French are acceptable for registration but it is a definite advantage to speak the language of the majority in the institution or region. As of 1 July 1976, all applicants (Canadians or immigrants) for registration/licensure in Quebec will be required to have a working knowledge of French.Presently, this requirement applies only to non-Canadians. Candidates who do not comply with this requirement must take a course offered by the Government of Quebec and write a French language test within a year. During that year, they may be given a temporary permit to practice if they meet all the other requirements of the nursing legislation and have been assured employment in a specific center. This permit is not renewable except with the authorization of the Lieutenant-Governor-in-Council when it is in the public interest to do so.

All other Canadian provinces require a working knowledge of English. Non-Canadian candidates who have taken their nursing program in a language other than English can be required to pass the Test of English as a Foreign Language (known as the TOEFL test), with a score of 450 to 500. Candidates must make their own arrangements for this test by writing to: Test of English as a Foreign Language, P.O.B. 899, Princeton, New Jersey, 08540, U.S.A.

In Alberta, New Brunswick, Quebec, Saskatchewan and Newfoundland nurses who have not practiced for more than five years (10 years in British Columbia) are asked to take a refresher or orientation course. In other jurisdictions, this requirement is dependent on individual assessment.

Most registering bodies require that candidates submit a birth certificate, marriage certificate (where applicable), reliable references, language test results, a description of the general nursing program completed, a transcript of student records, the results of the registration examinations, proof of current registration or eligibility for renewal of registration and registration number. Non-Canadians are sometimes asked for a copy of their secondary school diploma.

All documents should be written or translated in the official language of the province where registration is sought.

Registration procedure and possible delays

The length of time required to obtain registration is almost impossible to determine in advance. The entire process may take from a few months to more than a year, depending on a wide range of factors. Steps vary from one province to the other, but usually include the following:

The applicant writes the registering body expressing her intention to become registered or asking for information on registration in that province. At this point, a brief resumé of her qualifications helps to speed up the process.

She then receives an information packet and forms to be completed by the original registration body, by the director of the school of nursing where the nursing course was taken and perhaps by her previous employer. If the applicant's mother tongue is not the working language of the province, she usually receives information on the language test.

Upon receipt of the required certificates and completed documents, plus the processing fee, the registration body takes note of the documents and sends for confidential references. Delay may occur here if the previous employer fails to respond.

When these credentials have been assessed, the applicant is informed of the results.

Applicants who are required to take a language test, refresher courses, undergo medical assessments, obtain work experience or write examinations, will encounter a delay at this point. Other delays can occur if applicants, employers, directors of schools of nursing or previous registration body fail to send all the required documents. Often the transcripts are lacking some important information and much correspondence follows. In many instances, the application must be submitted to the committee on registration for consideration. In addition, the province to which the candidate is applying may have a large number of applications to process. When this occurs, a backlog forms which further delays results.

Once the application for registration is complete, the applicant is advised, given a registration number and requested to pay the registration fee. A registration card will probably arrive a few weeks after the official notice has been given.

If you follow these steps, and no special problems arise, your application should be processed smoothly in a relatively short space of time. Be prepared, however, to recognize possible sources of difficulty or delays in the process, handle a good deal of correspondence, and wait awhile before receiving a definite answer.

How to seek employment

It is the applicant's responsibility to seek out and find employment; therefore, it is desirable to have a job offer before moving to a province. Information on working conditions and job opportunities may be obtained from various hospitals; a list of these is usually sent by the registration body upon request to candidates who qualify for registration. If not, candidates are referred to reliable sources of information.



If you are moving to Canada...

Over and above requirements outlined for Canadian nurses, nurses who graduated outside Canada and who are registering here for the first time must also meet the following general requirements: (Note: each jurisdiction may also set individual requirements).

- have completed a general nursing program in a country or state where there is written nursing legislation (candidates having only a specialized course such as midwifery are not eligible);
- have received during that general program between 500 and 800 hours of theory and from four to eight weeks of clinical experience in medical, surgical, obstetrical, pediatric and sometimes psychiatric nursing;
- be a Canadian citizen *or* landed immigrant *or* hold a working permit (the registering body cannot intercede with the federal Department of Immigration on the applicant's behalf);
- have a working knowledge of French if applying in Quebec.

Non-Canadian candidates for registration in British Columbia, Saskatchewan, Manitoba, Ontario, and New Brunswick will probably have to write the Canadian Nurses' Association Testing Service examinations unless they have written the National League for Nursing examinations in the USA. Candidates for

Applicants are advised to delay their departure until they are assured of eligibility for registration. No employer can commit himself to hire someone as an RN unless he is sure the person is eligible for registration.

Candidates who have to go to a province to follow courses, write exams or take supervised training for a few months can sometimes obtain a temporary permit pending registration. Requests for temporary permits are assessed individually.

How much will it cost?

It is easy to forget that all this correspondence and duplication of documents, added to processing fees, registration fees, examination fees (where applicable), and living expenses pending registration can constitute a severe drain on your finances.

Fees for processing an application vary at the present time from $5 to $15, and registration fees range from $6 to $100 depending on the particular nursing legislation and the structure of the professional body (see table one). The cost of registration examinations is approximately $15 for each of five papers. (These costs can be expected to rise).

A national system of registration .... why not?

If you are now wondering why there is no national system of registration, read on. The following sequence of events may throw some light on the question.

National — as opposed to provincial — registration has been a concern since the turn of the century. Even before provincial statutes delegating authority for registration/ licensure were passed in each province, efforts were being made to permit Dominion registration for nurses. One of the earliest of these was a bill proposed by a Member of Parliament from Toronto. He asked the Federal Government to authorize creation of an Association for Trained Nurses of the Dominion. Although the bill received approval by the House of Commons, it was rejected by the Senate. A similar bill, drafted in 1938 also failed to become law.

In 1932, following publication of the first national survey of nursing education, delegates to the annual meeting of the Canadian Nurses' Association appointed a Committee on Dominion registration to formulate some plan whereby a more uniform standard of RN examination might be established throughout the Dominion.

The 16-member committee included representatives of CNA and each province. They studied the question for six years and finally proposed creation of a Canadian College of Nurses or Canadian Council for Dominion Registration of Nurses to permit voluntary registration on a national basis. However, some provinces opposed the suggestion and CNA decided that the question should be reopened when greater unanimity of opinion warranted further study.

In 1956, a CNA Task Committee on Special Aspects of Registration Requirements was formed with a mandate to study this question again. Instead of reciprocal registration, the Committee recommended that CNA concentrate on a national accreditation program and adopt a national system of licensing examinations. It also pleaded that provincial registration authorities demonstrate greater flexibility in the assessment and evaluation of nursing qualifications and suggested that the question of national registration be postponed again.

Role of the CNATS

It seems obvious that a national system of registration would offer immediate advantages in terms of individual nurse mobility. The political structure of this country, however, makes this difficult, if not impossible, to achieve. Canada is a federation of ten provinces, each responsible for its own education and health services. The organization of the nursing profession reflects this structure. Each province has its own nursing legislation; provincial responsibility for registration, licensure, approval of schools of nursing, etc. are already established. Standards in these areas have been set to meet specific needs in each province. It is unrealistic to expect these to be identical across Canada.

Nevertheless, a significant alternative has been achieved. In 1970, the CNA established a National Testing Service to prepare examinations for graduate nurses seeking registration. All provincial registering and licensing bodies are free to use this service for both graduate nurses and nursing assistants. To date, the French graduates of Quebec are the only ones not writing the CNATS exams. This is because these exams were originally written in English and subsequently translated. French Exams will be finalized by 1978.

Success in registration examinations is only one of the requirements to become a provincially registered nurse, but the use of the same registration examinations at least provides one nation-wide standard for admission to practice.

Nicole Blais is with CNA Information Services, Ottawa.

registration in Alberta, Quebec, Nova Scotia and Newfoundland may be asked to take courses, sit for exams or undertake a few months' probation, depending on their educational background and clinical experience.(The regulations of the Northwest Territories Association in this matter were not available at the time this article was produced, since it was recognized as a registering body only a few months ago.

Applicants coming to Canada without completing these requirements may find jobs as graduate nurses (although these are scarce) or obtain a temporary permit.

At the present time, registration examinations are written in January, June and August and it can take a few months before the results are announced.

If you are moving *out* of Canada...

Nurses wishing to obtain employment abroad should take advantage of the Nursing Abroad Program of the International Council of Nurses. For information, write to: Nursing Coordinator, Canadian Nurses' Association, 50 The Driveway, Ottawa, Ontario, K2P 1E2.

Participation in the Nursing Abroad Program is made possible through CNA's affiliation with ICN.

Table I **Provincial Registering Bodies**

Registered Nurses' Association
of British Columbia,
2130 West 12th Avenue,
Vancouver, B.C. V6K 2N3.

Alberta Association of Registered Nurses,
10256—112th Street,
Edmonton, Alberta, T5K 1M6.

Saskatchewan Registered
Nurses' Association,
2066 Retallack Street,
Regina, Sask. S4T 2K2.

Manitoba Association of Registered Nurses,
647 Broadway Avenue,
Winnipeg, Manitoba, R3C 0X2.

College of Nurses of Ontario,
600 Eglinton Avenue East,
Toronto, Ontario, M4P 1P3.

Order of Nurses of Quebec,
4200 Dorchester Blvd.,
Montreal, Quebec, H3Z 1V4.

New Brunswick Association
of Registered Nurses,
231 Saunders Street,
Fredericton, N.B. E3B 1N6.

Registered Nurses' Association
of Nova Scotia,
6035 Coburg Road,
Halifax, N.S., B3H 1Y3.

Association of Registered Nurses
of Newfoundland,
67 LeMarchant Road,
St. John's, Nfld. A1C 2G9.

Association of Nurses of Prince Edward Island
76 Euston St.,
Charlottetowr, P.E.I. C1A 1W2.

Northwest Territories
Registered Nurses' Association
Box 2757, Yellowknife, N.W.T.

At Last...

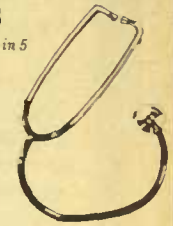


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#702	7¼"	$3.75

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#706 5" sharp/sharp **$2.85 each**
#710 4½" IRIS scissors **$3.65 each.**

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Kelly Forceps #725 Curved, box-lock **$4.35 each.**
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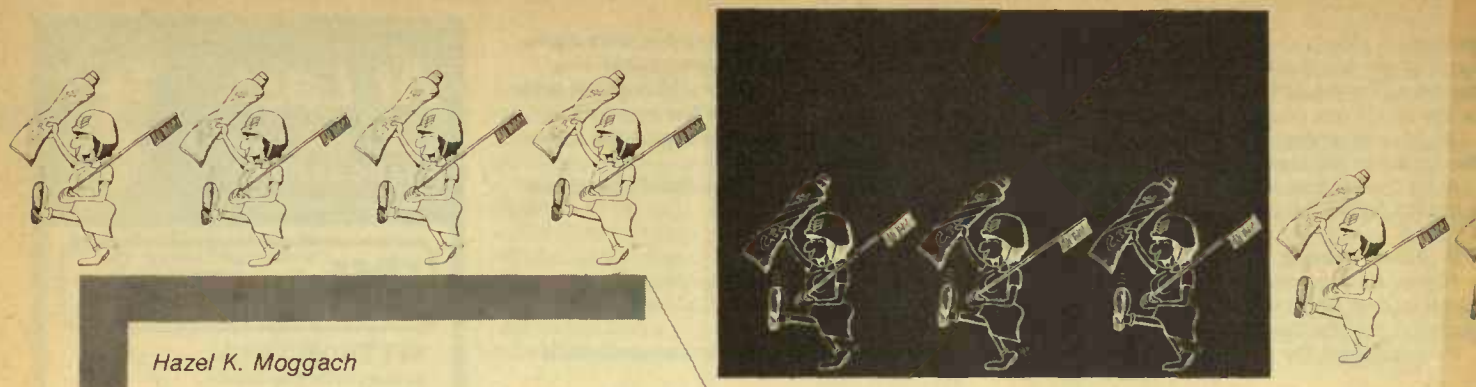
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Brushing Brigade

Hazel K. Moggach

Of course, there had to be a better way. Although two nurses had been trained as dental preventive technicians a year previously, they were still unable to organize a system to ensure that the 750 adult retarded residents of our Centre had clean mouths and teeth. Yes, there had to be a way . . .

For nearly a year, our dentist had carried out her moral and professional responsibilities to ensure that her services were benefiting the residents who received them. She had communicated with the administrator, the supervisor, and the counsellor regarding the implementation of new and efficient programs. The residents kept their dental appointments, but they had dirty, foul-smelling mouths and discolored, plaque-infested teeth and gums.

The usual excuse was: no time for cleaning teeth as other activities had high priority; besides, some residents had aberrant biting habits.

The dentist decided to go outside her "sanctuary," the dental clinic, to set up a tooth-brushing program and man the project each evening for six weeks. She wanted to see for herself and assess the difficulties encountered in helping severely retarded persons with oral hygiene.

Her research sample was the 35 male residents of a renovated hospital ward; the tooth-brushing procedure was to be accomplished in a relatively confined area that had two small sinks. A staff member prearranged the schedule and cared for the equipment; the brushing started at 18:00 hours, when the dentist arrived. She applied paste to the tooth brush and did all the brushing (33 ml tooth paste was used at each session).

The first brushing session was completed in 90 minutes; the second, in one hour; and eventually they needed no more than 40 minutes.

The residents' gums bled profusely the first evening. The bleeding gradually decreased with conditioning, until it ceased after one week. On one occasion, a male staff member was grabbed in the genital area. The dentist did not consider that this was done with intent to harm. She did suggest, however, that the staff learn how to grasp a resident's head and maintain a firm grip before taking over the program.

One highly motivated, mute resident seemed to sense the dentist's time of arrival, so did what he could to get his peers into formation, and the brushing materials in order.

From her study, the dentist concluded that, if counselling staff schedules a daily tooth-brushing place and time and knows the art of gripping the head firmly to ensure optimum vision and stability, the residents can be motivated to accept oral care daily and to need a minimum of staff and time for it. Also, with improvement in a resident's motor coordination, she expected even the most severely retarded person to practice personal hygiene daily with minimal reinforcement and assistance from staff members.

The dentist communicated effectively with the other members of the health team — not only by what she said, but how she said it and her firm belief in what she said. Now the nursing staff carry on the tooth-brushing program throughout the Centre, and it goes like clockwork.

Hazel K. Moggach, R.N., B.A., M.Ed., is acting coordinator of human resources at the Oxford Regional Centre, Woodstock, Ontario. Sophie Rozycki, D.D.S., D.D.P.H., who was then the Centre's dental coordinator, set the oral hygiene program in motion.

Blindness *can* be prevented



As a nurse, you have a responsibility — to yourself and to your clients — to know what can be done to prevent blindness.
Fifty percent of all blindness is preventable.
Which half will **you** be classified in?

Fern Doner



Today, prevention is a top priority in all areas of health care. In theory, we are doing quite well; in practice, our actions do not match our words. Physical fitness experts warn that lack of exercise and poor eating habits are leading more and more Canadians to the coronary care units of our hospitals. "The Department of National Health and Welfare advises that danger to health increases with amount smoked" but the number of smokers continues to climb. We know more about prevention than we care to admit but we are great procrastinators. When was the last time you had a complete physical? When did you last visit the dentist?

You the Nurse

The nurses' role in preventive health programs can be divided into two areas; that of observer, and that of teacher or informant.

Eye care begins at birth. Although the initial examination is the responsibility of the doctor, the nurse should be aware of possible congenital problems, e.g., cataracts, hazy cornea, subconjunctival hemorrhages, hemangioma (nevus flammeus), crossed eyes due to sixth nerve palsy, conjunctivitis and dermoid cysts. The symptoms of infantile glaucoma — irritability, tearing, and photophobia require immediate attention to prevent blindness.

Health care personnel, particularly the nurse, should make parents aware that, if all is well, their baby will start to follow light at three months of age, and will start reaching for objects at four to six months. A baby's eyes should be straight by the age of six months and though the parents may only think that "the baby's eyes look funny," it is better to be sure by having an examination.

Strabismus which appears after the child is a year old may be caused by a number of other conditions needing immediate treatment, including congenital malformations, cataracts, corneal opacities, uveitis and tumors. A white pupil may suggest cataract, retinoblastoma, or retrolental fibroplasia — a condition found in premature babies who receive high concentrations of oxygen. Preventive health care by the nurse involves stressing the need for early treatment of strabismus to the parents.

The public must continually be exposed to the potential hazards in their immediate environment through lectures, films, pamphlets, and "nagging". The attitude is always — "it could never happen to me." But it can and does, and nursing has a responsibility to reinforce these preventive health programs. For example:

- *R.T., a 14-year old boy, took a drink from a bottle he found in his father's truck. Today R.T. is legally blind from optic atrophy because the bottle contained antifreeze. He functions in school using a low vision aid and large print type.*
- *Mr. D.H. decided to stop taking his glaucoma drops for awhile because he was having headaches. Fortunately, the nurse stopped in for a regular visit and explained why it was necessary that the drops always be taken as ordered by the doctor. Although D.H. will use glaucoma drops for life, he can still see today to manage his hardware store.*

The nurse should be informed about the use and abuse of contact lenses. With the growing popularity of these optical aids, frequent questions are posed to the nurse by wearers and prospective wearers. Are they aware of the necessity of following the cleaning routine? Do they stop wearing the lenses when their eyes feel irritated or sore and contact the doctor? All this knowledge belongs to the nurse.

Sadly, one of the slogans least likely to be followed is, "Be Wise, Take Care of Your Eyes." This fact is a major concern of The Canadian National Institute for the Blind (CNIB) whose founder, Colonel E.A. Baker, instituted the prevention of blindness program in 1918. Each of the eight divisions of CNIB has a prevention of blindness program. Some Provinces (i.e. Ontario, Quebec, and Newfoundland) have a specialized area of prevention in the Mobile Eye Care Units (MECU).

Mobile Eye Care Units

The Mobile Eye Care Units are ophthalmologist's offices on wheels. They travel into rural areas not already served by a resident ophthalmologist, providing eye examinations, testing, and minor surgery on an emergency basis. The vans are staffed by ophthalmologists from across Canada who volunteer their services for one- or two-week periods, and by trained CNIB staff who coordinate the programs in each community with the help of service clubs, local doctors, and the Public Health Departments. People needing further care or follow-up are referred back to a local doctor or Public Health nurse.

Industrial Hazards

The necessity for wearing safety glasses in industry is well publicized by the Wise Owl Club of Canada. Employees who have saved their sight by wearing eye safety equipment are eligible for membership in this club. The Wise Owl Club began in 1947 as the result of an idea dropped into a suggestion box at a plant in St. Louis, Mo. The Canadian equivalent was formed in 1957.

There are three main concerns in industry: the chemical splash, the radiation burn, and the foreign object.

One of the many instances of eyesight being saved by the wearing of safety lenses is that of Mr. F., a millwright helper for Inter-Provincial Steel and Pipe Corporation Limited, Regina. Mr. F. was putting an arch in front of an electric furnace while another crew member was gunning the furnace from the inside with an air gun. Somehow the gun slipped and Mr. F., who was in front of the furnace, received the full blast in his face. Although the force of the flow broke one of his safety lenses, his eyes were undamaged.[1]

Hazards at home

Safety lenses should also be used in the home. Sawdust or paint can easily blow into your eyes when doing woodwork or painting. But, prevention of blindness involves more than wearing safety glasses. Hazards in the home are easily overlooked:

- Spray cans that dispense hair spray, perfume, deodorant, insect repellent, air fresheners, cooking aids, paints, and waxes for example, represent potential hazards, especially for preschoolers.
- The ingestion of corrosive or alcoholic liquids such as antifreeze or cleaning agents can cause optic atrophy and permanent blindness.
- Homemade and unsupervised fireworks displays, scissors, knives, pellet guns, and elastic bands can also be a great hazard to both children and adults.

Hazards in Sports

A survey of the 1973-74 hockey season by the Canadian Ophthalmological Society reveals that this popular sport poses serious potential hazards to the players. Eye injuries were numerous; they ranged from broken socket bones to nerve damage, hemorrhage and cuts on the eyeball from sticks and pucks. Six percent of these injuries resulted in legal blindness.* Another sport that is causing concern in ophthalmologists' offices is squash, a game of increasing popularity, but, with a ball as hard as a stone that fits neatly into the eye socket.

* A person is considered blind if the visual acuity in both eyes with proper refractive lenses is 20/200 or less with the Snellen chart (or equivalent) or the greatest diameter of the field of vision in both eyes is less than 20 degrees. (As defined in the Blind Persons Act, Ottawa, Can., July 1962.)

Car Safety

"Buckle up for safety" is another preventive slogan which goes unheeded. Some provinces are considering legislation to make the wearing of seat belts mandatory. Certainly, seat belts (done up!) can save your life; they can also save your eyesight. Eye injuries in car accidents are far too common, especially among children. They are just the right height to suffer a concussion from knocking their heads against the dashboard on a sudden stop.

Eye Examinations

There is nothing to fear from a visit to the eye doctor, but a regular checkup by an eye specialist is another example of our tendency to procrastinate. In Saskatchewan, yearly eye examinations are covered by a Health Plan up to the age of 17 years, every three years from 17-46, and then every two years over the age 46. Once a person reaches approximately age 25, he should have a regular examination for glaucoma. This is a simple, painless test. Glaucoma when diagnosed early can be controlled by drops; left untreated, it can lead to blindness. Glaucoma surveys are conducted periodically by CNIB and positive readings are referred to eye specialists for treatment.

CNIB and/or Public Health Departments also screen preschool children for amblyopia. Amblyopia, or "lazy eye", is a condition in which one eye has poor vision, although there is no disease or malformation present. One of the main causes of amblyopia is strabismus or crossed eyes. The child suppresses vision in the turned eye to avoid seeing double. This eventually leads to very poor vision. After approximately the age of seven years it is too late to correct the situation, therefore the treatment of amblyopia must begin early.

Home Eye Test

Recently, a home eye test has been developed and circulated by CNIB which enables parents to test their child's eyesight. The E-game includes a large black E, an eye patch shaped like a daisy, and three smaller E's in graduated sizes. The child is seated on a chair ten feet away from a light-colored wall. The daisy eye patch is placed over one eye at a time and the child holds the large "E" He is then asked to point the hands of his "E" in the same direction as the "E" that mother is holding up to the wall.

If the child has trouble with any of the sizes, the parent is instructed to arrange for an eye examination. Signs and symptoms of possible trouble such as dizziness, frequent rubbing of eyes, crossed eyes, and stumbling over small objects, are listed in the pamphlet with the E-game. The text of the pamphlet is approved by the Canadian Ophthalmological Society.

Eye Q Test

1. How large is Canada's blind population?	29,000	17,500	41,000
2. Of 3,187 people seen at Mobile Eye Care Units in Ontario in 1973, (MECU) how many reported having had no previous examinations?	874	253	631
3. What percentage of people seen in the MECU have some problem related to an abnormality of the eyes?	48	73	81
4. What was the third leading cause of blindness in 1974?	accidents	infections	glaucoma
5. How many people were blinded in 1974 from injuries and poisonings?	22	81	52
6. How many eye injuries are on record as having occurred during the 1973-74 hockey season?	279	102	589
7. Which group has more injuries?[2]	Organized hockey		Unorganized hockey

Answers: 1. 29,000 2. 874 3. 73 4. glaucoma 5. 52 6. 279 7. organized

Progress

Medicine makes rapid advances and no one knows when a breakthrough in ophthalmology may come, enabling many of our blind population to see again. Even today, some people have regained their sight as the result of corneal transplants and the work of the Eye Bank of Canada. Research into the effect of diabetes on the eyes will someday provide an answer to that cause of blindness. Vaccination for rubella has virtually wiped out those statistics and now in some provinces, preadolescent girls are routinely vaccinated as part of the school health program. The National Retinitis Pigmentosa Foundation of Canada was founded last year to direct research into a cure for this disease which strikes primarily children and young adults. **It is estimated that 50% of all blindness is preventable. Which half will you be classified in? Take care of your eyes: they must last a lifetime.**

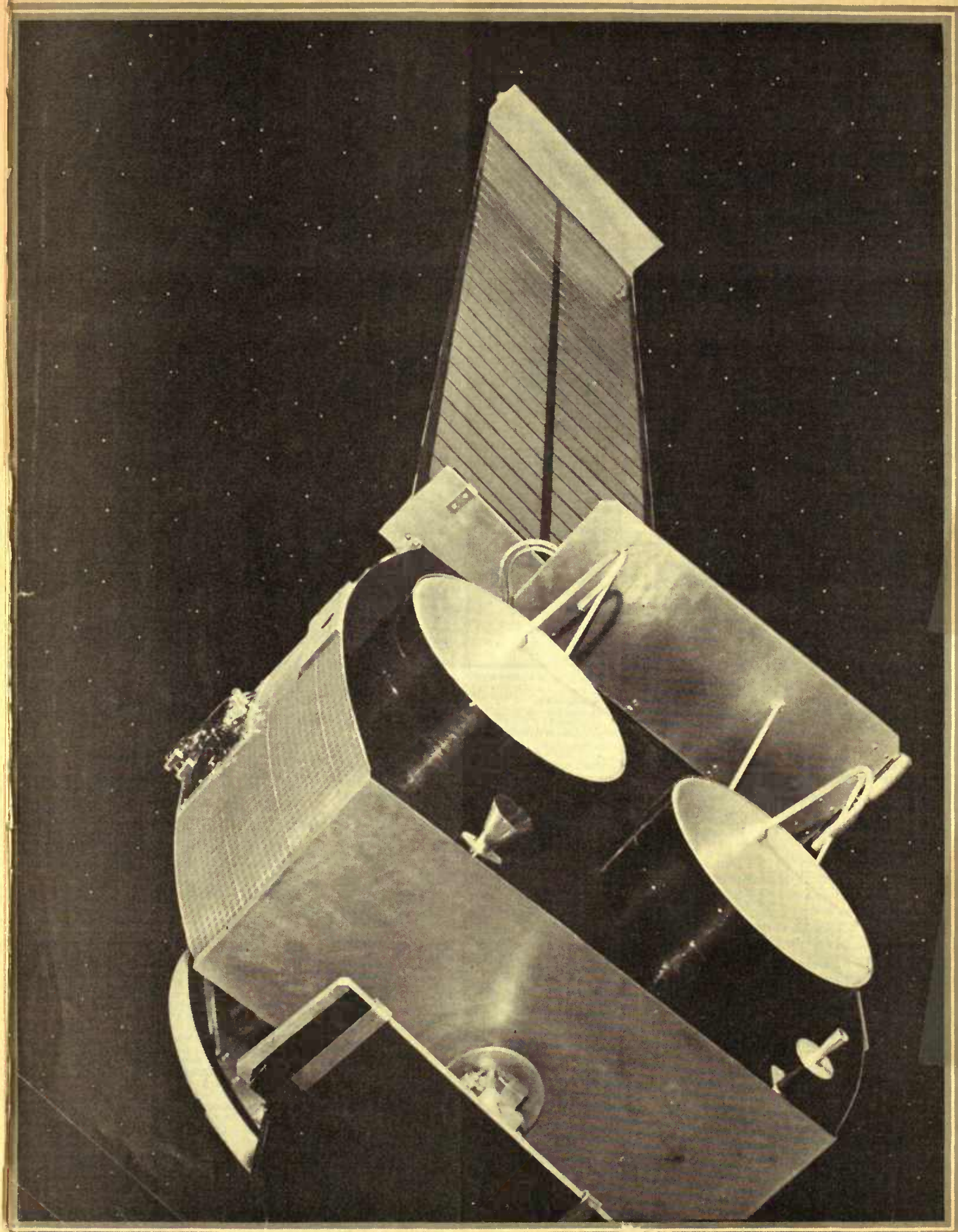
Fern Doner (R.N. Toronto East General and Orthopedic Hospital) is Supervisor, Prevention of Blindness and Eye Service for CNIB, Saskatchewan Division, Regina, Sask.

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Nursing via SATELLITE

Modern telecommunications are helping to bridge the gap that often separates northern citizens from the medical assistance they need.

Nicole E. Henderson

Most of us use the telephone, turn on the radio or television and find out what is going on in the world without giving a thought to the technology involved. Telecommunications are an integral part of the professional and private life of those who live in southern Canada. In the northern areas of the provinces, the Northwest Territories and the Yukon, it is a different story: reliable communications can be a matter of life and death.

Notaraluk Ijaituk of Ivujivik, Quebec, knows this from personal experience: *"It was in September of 1970 that it happened. My son was about four months old at the time. He got what seemed like an ordinary cold; the first he'd had. We were not too worried at first but then it got worse. We radioed the nurse in Salluit and she told us what to do. There was no nurse here, and so there were three Inuit and a white man all helping to look after the baby. The baby seemed to be getting better after a while, but he suddenly got very sick just as the radio faded out. For three days we could not raise anybody on the radio. During this time the baby was hot and sweating all the time and he couldn't eat. We were sure that he would never pull through. Finally, on the third day, we were able to get a message out for help and a plane came. As we put the baby on the plane, my wife thought he was already dead. The plane rushed him to Salluit, and there the nurse put a tube down his throat and took out the poison in his lungs and he is living now. The thing that really worries me is that the radio is no different today than it was then. The people here are always worried that someone will die here because of that radio."*[1]

Communications take on a special importance for northerners because, although there are 58,000 of them, they are spread over an area of 1.5 million square miles — approximately 40 percent of Canada. This isolation is a serious problem for people whose health is constantly threatened by accidents, inadequate sanitation and mental stress. Dr. H.B. Brett, principal medical officer with the Medical Services Branch of Health and Welfare Canada, says that mental health problems affecting both native and non-native can be crucial in isolated settlements where the interaction between different cultures can create difficulties and where the pattern of education separates families for months on end. He points out that there is a lack of psychiatric facilities in the north.[2]

In addition, infant mortality rates are high — estimated at 89 per 1,000 live births for the Inuit in 1968, and 49 for the Indian people — compared to 21 for the whole of Canada.[3] Accidents, poisoning and violence (suicide included) accounted for 33 percent of all deaths in the Yukon and N.W.T. in 1973. Neoplasms, diseases of the circulatory system, and respiratory problems rank next in significance. Dr. Brett believes that better telecommunications, especially radio, would help to improve health conditions in the north.

Health and Welfare Canada is acutely aware of the health problems faced by northerners. The department operates 72 nursing posts (37 of them in the N.W.T.) staffed by nursing practitioners. Four of its 13 hospitals are beyond the 60th parallel — all have at least eight beds and a resident doctor.

There is great variation in the communication services available to support northern health services. Dr. H.J. Bagnall, a consultant with Medical Services, says, "Generally speaking, the most isolated posts have only high frequency (HF) radio. (HF radios reach great distances by bouncing the signals off the ionosphere.) There are 16 posts of this type. Radio communications can be cut off for days by disturbances in the ionized part of the atmosphere (ionosphere) which, incidentally, also create the northern lights. Other organizations such as the Hudson's Bay Company or the Royal Canadian Mounted Police (RCMP), whose radios are more powerful, can often be of help in these circumstances. There are times, however, when no one can establish communications with the outside." Other posts have very high frequency radio which is suitable for linking stations about 40 miles apart on flat ground.

A more sophisticated system is used by nursing stations and hospitals in the Mackenzie Valley, where Canadian National Telecommunications (CNT) has microwave links between Yellowknife and Inuvik. The Yukon has a system of land lines in addition to microwave links.

Hundreds of miles of wires, or microwave towers spaced 30 or 40 miles apart, are required to carry telephone, telex, radio or television services. Systems of this type are expensive and tend to be located in the more accesible areas where population density and level of development make them economically feasible.

Other northern health care stations, such as the hospital at Frobisher Bay, are linked to the telecommunications network by satellite. The advantage of satellite communications is that they are not







subject to disruption by atmospheric disturbances. The earth stations they require can be installed fairly easily and with minimal lead time.

Satellites became part of Canada's telecommunication system in 1973. Operated by Telesat Canada, a commercial corporation, the channels in the three Anik satellites are leased by such companies as the Canadian National Telecommunications (CNT), the Canadian Broadcasting Corporation (CBC) and Bell Canada. Besides transmitting television and telephone in southern Canada, satellites provide northern communities with telephone, radio and television services. Dr. John Chapman, assistant deputy minister, space programs, Department of Communications, notes: "There are, at present, 10 communities in the N.W.T. and seven communities in Ontario and Quebec served by Anik with telephone services . . . In the Yukon and Northwest Territories, 33 communities receive radio and 22 communities receive television . . ." Dr. Chapman predicts: "In the next seven to ten years, all communities with over 200 people are expected to be able to receive radio, and communities with over 500 people are expected to be able to receive television."[3]

In the near future, a new breed of high-powered satellites will push back the frontiers of communications. In this context, the federal Department of Communications this month launches the experimental Communications Technology Satellite (CTS). It will test the feasibility of using mobile earth stations much smaller than those used by traditional lower-power satellites, and will be light enough to be carried on a big sled or in a bush plane. CTS will be able to transmit voice, images and data to and from these small terminals. It will also be capable of two-way transmission of voice alone or voice plus video. CTS is a joint project with the United States and satellite time will be shared equally by the two countries. The satellite was designed and assembled at the Research Centre of the federal Department of Communications near Ottawa.

In 1972, the department invited interested Canadian groups to suggest experiments using CTS. Universities, federal and provincial governments, native groups, private industry and broadcasters submitted proposals. Possible applications of the satellite have been discussed at a number of meetings between the department and researchers. As a result, a series of technical and social experiments will be carried out, involving telemedicine, tele-education, cultural exchanges and television programming by native groups, during the expected two-year lifetime of CTS.

Telemedicine has been described as a "mode of delivering medical care (which) serves to replace the physical presence of a physician with an electronic presence" [5], or the practice of medicine at a distance. It seeks to extend to isolated areas the professional hospital and health care services available in larger centers, and to facilitate the exchange of information essential to better diagnosis and treatment. Telemedicine systems can be used for distant consultations among nurses in remote areas as well as for continuing education.

Among the proposed CTS telemedicine experiments is one by Dr. Lewis Carey of the Health Science Centre, University of Western Ontario, involving three levels of health care. Under the proposal, the nursing station at Kasatchewan, a village on James Bay in Northern Ontario, would be equipped with a small dish-shaped antenna one meter in diameter. This would allow the nursing station to communicate with the General Hospital at Moose Factory, which provides obstetrical, medical and minor surgical care. A second link would be established between the hospital in Moose Factory and the Health Science Centre of the University of Western Ontario, where specialists would assist in the interpretation of ultra sound images, radiographs or ECGs.

This experiment would assist in evaluating the usefulness of television as a tool for consultation, diagnosis, and triage. It would also demonstrate the degree of facility in maintaining the satellite link, and whether the work of the nurse or resident doctor is made easier or more complicated by communications technology.

Another CTS telemedicine experiment has been proposed by Memorial University of Newfoundland under the direction of Dr. M. House. The University plans to transmit medical education programs to four communities. The effectiveness of live audio and video interaction would be compared with the present system involving the circulation of videotapes by mail. This experiment would also evaluate the effectiveness of telehealth education in areas such as nutrition, family planning and accident prevention. In addition it would enable doctors to consult through audio channels.

Before participating in the CTS experiment, the group is testing techniques such as the use of slow-scan equipment to transmit still pictures of X-rays over telephone lines: in February, a room-to-room link, for example, between the emergency and X-ray service will be





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established at St. John's General Hospital. In April 1976, a microwave link will be set up between the General Hospital and the Health Science complex at Memorial University to be used in continuing education for doctors, for administrative purposes and as a means of following up on inpatient visits.

Two other telemedicine projects are scheduled to be carried out on CTS. One of these involves the supervision of health care delivery in the Queen Charlotte Islands. The other is a purely administrative project to be undertaken as part of a multiministry operational experiment by the province of Ontario.

In Canada, telecommunications have not yet been perceived as an integral part of the health care system. Anna Casey-Stahmer, a social policy analyst with the Department of Communications, is of the opinion that procedures will have to be set up to ensure the most effective integration of health care and communications. "At present, information is being collected on this subject. It appears that only rarely are arrangements made to routinely schedule telephone visits between physicians and remote nurses, even where reliable communications exist. An overall objective of the telemedical experiments is to assess the utility and cost-effectiveness of telecommunications in supporting quality medical care and in providing the greatest access to such care."

Two telemedical experiments carried out in Alaska through the ATS-1 (1971) and ATS-6 (1974) clearly demonstrated the importance of regularly scheduled contacts between doctors and health aides. The first carried only an audio link while the second had audio and video interactive links. Both experiments took place under the auspices of the Indian Health Service of the U.S. Department of Health, Education and Welfare.

A report of the results of the first experiment, carried out using an audio link via ATS-1 showed that; "Satellite villages had an increase of about 500% in the number of contacts completed and 400% in the number of health aide-to-doctor consultations over those villages with HF radio... In half the consulting cases, the doctor believed the health aide had planned or could have planned correctly using his or her own judgment. Of the remaining cases, 20% required minor changes, and 30%, major changes... At the Alaska Native Medical Center, the average length of stay has decreased, with the largest reduction occurring among patients brought in from satellite villages."[6]

Both the ATS-1 and ATS-6 satellites were used in the second experiment, which had video as well as audio capabilities. The system also made it possible to transmit X-ray photos and electrocardiograms, and to hold long distance pediatric and other medical consultations. A sound amplifier was included for transmitting heart, lung and abdominal sounds and used for auscultation and percussion. The communications system also gave access to statistics and medical files.

This experiment provided a unique opportunity to test a wide range of telemedical methods. It showed, among other things, how television could relay information on eye movements, gait abnormalities, patient response to palpation and visual evidence of patient distress.

Dr. Martha Wilson of the Alaska Area Native-Health-Service, Anchorage, a participant in the experience, reported to the Canadian Telemedicine Symposium held last October in London, Ontario, that teleconsultation, carried out in a routine and systematic way, had given both patients and health care personnel a sense of security.

Experiments such as these may provide a useful frame of reference for Canadians, but they cannot give us all the answers for all situations. In planning for telemedicine, health care specialists, telecommunications planners, behavioral scientists and economists must work together to develop worthwhile, economically feasible experiments and to evaluate the results fairly. We must find ways to benefit from all that technology has to offer, while recognizing that it has its limits as well as professional and legal implications.

The author is assistant director of the information directorate of the federal Department of Communications. She has also worked with Health and Welfare Canada and is a former associate editor of L'infirmière canadienne.

Communicable Diseases and Immunizations

Lynda Cranston

Canadians are becoming overly complacent about diseases that can now be prevented. Nurses should continuously reinforce the need for primary immunization and maintenance doses. Emphasis *must* be placed on *prevention* not treatment.

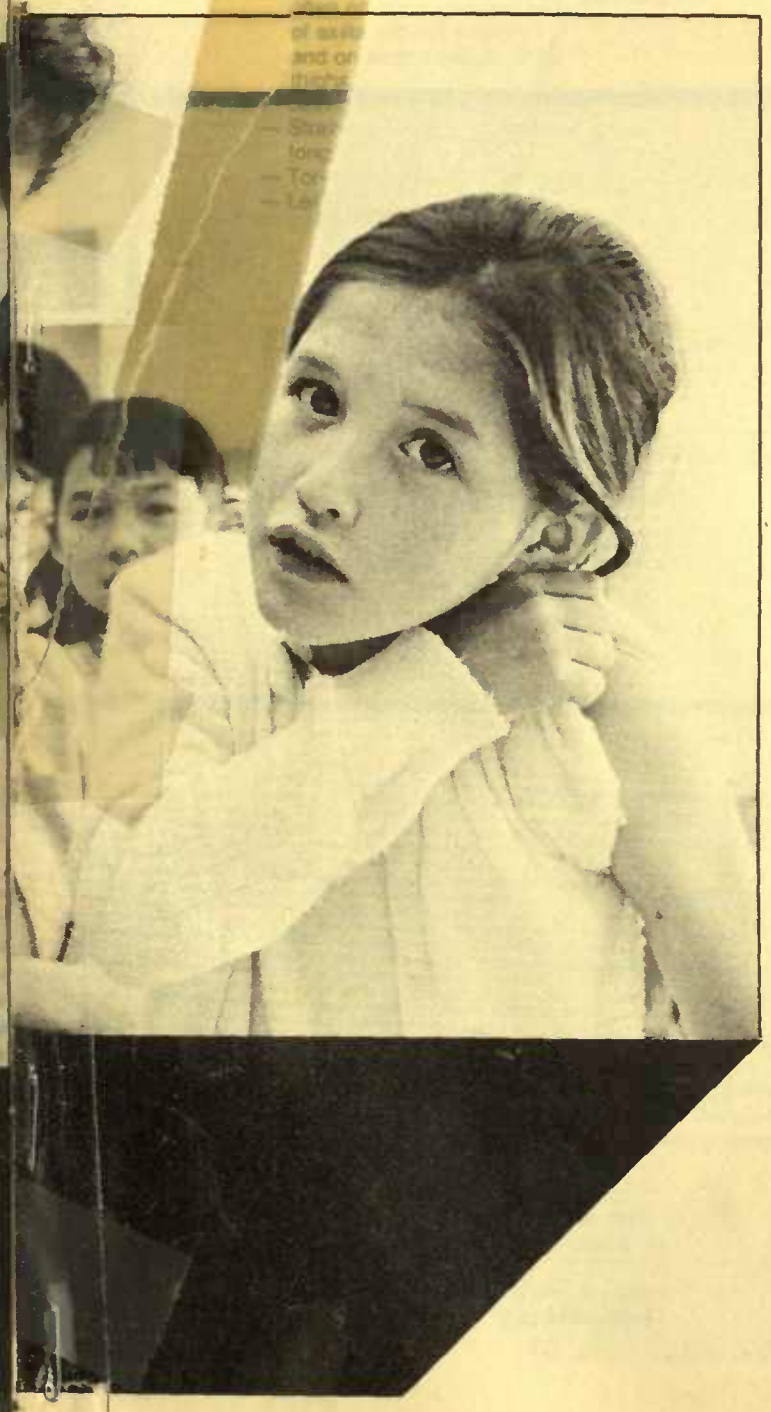
Improvements in living conditions, immunization practices and treatment have greatly reduced the incidence of communicable diseases throughout the world.



In Canada, for example, only four cases of poliomyelitis occurred in the past ten years, compared with 1,000 cases annually in the preceding decade (1955-65). These figures indicate that we are close to achieving optimal control in the prevention of this crippling disease. Significant reductions have also been made in the incidence of other communicable diseases — for example, whooping cough (pertussis).

Most Canadians, and all health professionals, are aware of these trends. What they are inclined to forget, according to officials of the Epidemiology Bureau of Health and Welfare Canada, is that these gains could be wiped out by carelessness. They warn that Canadians are becoming overly complacent about diseases that can now be prevented. As proof, they cite epidemics of diptheria that have occurred within the past three years in Newfoundland, Quebec, and British Columbia.

Some immunization programs have been slow to gain acceptance among Canadians. We lag behind the United States, for example, in using vaccinations that prevent rubeola (red measles) and rubella (german measles). Although both of these diseases are now considered preventable, Health and Welfare Canada figures indicate that in the first ten months of 1975, a total of 12,000 cases of rubeola and 11,000 cases of rubella had occurred. Rubeola has a treatment to prevention ratio of 20:1, that is, we treat 20 cases for every one that we prevent. Similarly, rubella has a treatment to prevention ratio of 10:1.

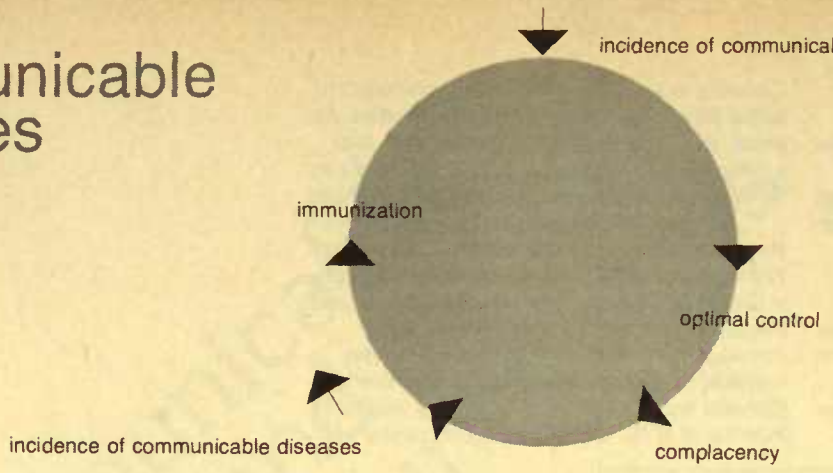


Both rubella and rubeola have serious implications for the victim, his family, the community, and the health care system. One of these consequences is a measurable increase in public health care costs. It has been estimated, for example, that the 2,000 cases of congenital rubella syndrome that occurred in Canada in 1964-65 will cost taxpayers close to half a billion dollars over the next 20 years. More recently, the province of Nova Scotia reported 30 cases of rubella syndrome in one year — 1975. Officials estimate that this health care bill will be $6 million over the next decade.

Two points seem clear: immunization programs can save both lives and money; they can also lead to the eradication of communicable diseases. The World Health Organization predicts that, within 12 months, smallpox will no longer be found on the face of the earth. Canada has not had a case of variola major for the last 25 years, and because the risk of reaction is now greater than the risk of exposure, vaccinations for smallpox have not been recommended since 1971 for primary immunization.

The nurse working in the hospital, in public health, and in doctors' offices has a challenging opportunity to teach, interpret, encourage primary immunization of all children, stress the importance of scheduling the vaccinations, and emphasize the need for maintenance of reinforcing doses and boosters. Only through immunization can we hope to have optimal control of communicable diseases.

Communicable diseases



Classification of Immunity

1. Natural Immunity
   - — species
   - — race
   - — individual
2. Acquired

	Natural	
Active	— by attack of disease	
Passive		— by placental transmission

	Artificial	
Active	— by vaccination	
Passive		— by injection of antiserum (prophylactic and therapeutic)

with: live organisms, attenuated ones, dead ones, toxins, toxoids, toxin — antitoxin

Schedule of Immunizations

D P T P	diphtheria pertussis tetanus polio	given at 3 months, 4 months, 5 months and 6 months to 1 year of age
D T P	diphtheria tetanus polio	given at 6 to 13 years of age every 5 years
T P	 polio	given at 14 years of age and over every 5 years
Tetanus toxoid		if booster over one year (depends upon policy — could be from 6 months to 3 years) give for laceration, burn, puncture wound, dog bite, and cat scratch (tetanus antitoxin given if no previous immunization.)
M M R	red measles (rubeola) mumps (epidemic parotitis) german measles (rubella)	given at 12 months of age in a single injection
	tuberculin	given at one year of age then once yearly

Scarlet Fever

Causative Organism & Transmission	Incubation and Identification	Diagnosis	Treatment	Immunization	Nursing Management	Complications
Organism Group A Hemolytic Streptococcus *Transmission* — by direct or intimate contact with patient or carrier	*Incubation Period:* 1-7 days (usually 2-4) *Identification* — Abruptly by fever (39.5° C) (normal within 5-6 days) — Vomiting, sore throat, headache, chills, malaise — 12-48 hours post onset typical rash: fine erythematous rash to dark & dusky then to desquamation appearing most often on neck, chest, in folds of axilla, elbows & groin, and on inner surfaces of the thighs — Skin is dry and scaly — Strawberry tongue to raw beef tongue — Tonsils enlarged & reddened — Lesions — not on face — forehead & cheeks are flushed — area around mouth pale (circamoral pallor) — Types Mild Septic Toxic	1. Clinical manifestations 2. Throat culture 3. Serologic tests	— Penicillin (Choice) — Erythromycin	None	— Isolation for 7 days (at home) — Push fluids — Good skin care — Hot saline gargles — TPR-q4h — Bed rest — Lotions for skin — Diet as tolerated	*Early* 1) Cervical Adenitis 2) Otitis Media 3) Sinusitis 4) Broncho-pneumonia *Late* 1) Rheumatic Fever 2) Acute Glomerulonephrit

(Pertussis) Whooping Cough

Causative Organism & Transmission	Incubation and Identification	Diagnosis	Treatment	Immunization	Nursing Management	Complications
Organism Bordet - Gengou Bacillus (Bordetella Pertussis) — High mortality in infants (1yr. —F)M-increasing mortality & morbidity rates *Transmission* by direct contact, by droplet, with discharges from laryn-geal and bronchial mucous membranes of infected persons.	*Incubation* — usually within 10 days *Identification* Clinical Course 1) Catarrhal 2) Paroxysmal 3) Convalescent 1) Catarrhal: 1-2 weeks S & S of URI-Sneezing, lacrimation, cough, low grade fever — in second week cough more severe & hacky 2) Paroxysmal: 4-6 weeks cough — explosive bursts, characteristic "whoop" (cyanotic or red in face) mucous, anxious, — Vomiting may follow coughing, severity increases 1st or 2nd week — Remain at same level 1-3 weeks. 3) Convalescent — Cessation of vomiting & whoop — Fades 1-3 weeks	1) Naso-pharyngeal swab (auger suction) 2) Clinical manifes-tations	Pertussis immune globulin for pts c̄ severe whooping cough ↓ Severity recommended for pts. under 2 years.	None at birth D.P.T.P. (6-8 weeks) — One attack → lasting immunity	— Bed rest as long as fever — Ventilated room — Eliminate factors that tend to increase coughing — — Activity, excitement, dust, smoke, sudden changes in temperature — Proper nutrition if vomiting — Small frequent feedings — O_2 if cyanotic or dusky — Suctioning — done if necessary (too often aggravates choking spell) — Choking — turn upside down pat on back — remove mucus from mouth c̄ kleenex. — Period of communicability 7 days after exposure to 3 weeks after onset of typical paroxysms (after 4th week organism seldom found)	1. Interstitial pneumor 2. Rectal prolapse 3. Bronchopneumonia 4. Atelectasis 5. Convulsions 6. Asphyxia from severe paroxysms 7. Nutritional disturbances

Mumps (Epidemic Parotitis)

Causative Organism & Transmission	Incubation and Identification	Diagnosis	Treatment	Immunization	Nursing Management	Complications
Organism Myxovirus Parotiditis Filtrable virus Virus enters through nose & mouth *Transmission* — Direct contact or droplet infection — Mumps virus has been isolated from human saliva, blood, urine & C.S.F.	*Incubation* 16-18 days *Identification* — Salivary gland enlargement particularly parotid glands — Parotitis (Uni or Bilateral) — Orchitis (20-35% of males) — Fever, headache, anorexia, malaise/localized pain near ear aggravated by chewing — Enlarged gland—max. size 1-3 days — T↓ 1-6 days — Swelling↓ 6-10 days	1. Serologic tests (complement fixation) 2. History of exposure 3. Clinical picture	Symptomatic & Supportive	— One attack lifelong immunity — Infants born of mothers who had mumps possess passive immunity — Live attenuated vaccine available	— Isolation — home (9 days from onset of swelling) — Oral hygiene — Fluids ↑→ soft diet — Nothing strong or acidic — Bed rest	1. Deafness 2. Neurologic complications — facial neuritis — myelitis — post infectious encephalitis 3. Pericarditis 4. Arthritis 5. Hepatitis

Red Measles (Rubeola)

Causative Organism & Transmission	Incubation & Identification	Diagnosis	Treatment	Immunization	Nursing Management	Complications
Organism Measles Virus *Transmission* — direct (droplet spread) contact with secretions of nose, throat and urine of infected persons — indirect — less commonly airborne	*Incubation* 10-11 days *Identification* — Fever & malaise within 24 hours normal. — Coryza, conjunctivitis & cough reach peak c eruption on 4th day. — 2 days before rash — *Koplik's spots* on buccal mucous membranes opposite molars — By end of 2nd day — T↓ & Koplik's spots disappear — Rash a) Rarely exceeds 5-6 days (Erythematous Maculopapular) b) Eruption appears first at hairline involving forehead, area behind ear lobe; upper part of neck c) Then spreads downward to involve face, neck, upper extremities & trunk d) Lesions on face & neck — confluent lesions on legs — discrete e) Rash fades in order of appearance f) Rash is purple-red in color	1. Clinical manifestations. 2. Serologic tests 3. Isolation of virus	Supportive	— One attack lasting immunity — Passive-pooled adult serum — Gamma globulin causes modified symptoms — Measles vaccine: a) Live attenuated vaccine (97% effective) b) Inactive measles vaccine (75% effective) Babies have passive immunity for approx. 6 months, if mother has had disease	— Isolate at home till 7 days after appearance of rash — Liquid or soft diet — Cough syrups — for cough if necessary — Eyelids cleaned with warm H_2O (Conjunctivitis) — Protect from bright light if photophobic — No longer contagious after 5th day of rash	1. Otitis Media 2. Mastoiditis 3. Pneumonia 4. Cervical Adenitis 5. Acute Encephalitis

German Measles (Rubella)

Causative Organism & Transmission

Organism
Rubella Virus

Transmission
— droplet or direct contact with patient

— indirect with articles freshly soiled with discharges from nose & throat

— airborne could occur

— infants with congenital rubella syndrome excrete the virus

Incubation and Identification

Incubation 16-18 days

Identification
— In a child, rash is first sign
— In adults & adolescents — 1-5 day period of low grade fever, headache, malaise, anorexia, mild conjunctivitis, coryza, sore throat & cough

— Rash
a) pinkish-red in color, first on face
b) then spreads rapidly downward (more quickly than measles)
c) by end of 1st day — whole body covered c maculopapules,
d) 2nd day begins to disappear from face
e) lesions on trunk — coalesce to form blush while lesions on extremities remain discrete and do not coalesce.
f) by end of 3rd day — rash disappears

Diagnosis

1. Clinical manifestations
2. Isolate virus
3. Serologic tests

Treatment
Symptomatic

Immunization

— One attack permanent immunity

— Gamma globulin to modify clinical manifestations

— Live attenuated vaccine (90-95% effective)

Nursing Management
— Bed rest

— No diet restrictions

— Isolate (at home) till rash gone

— ASA if increase in temperature

Complications
1. Arthritis
2. Encephalitis
3. If exposed during
a) 1st Trimester of pregnancy
— Congenital Anomalies
b) — 2nd Trimester of pregnancy
— Premature Birth

Chickenpox (Varicella)

Causative Organism & Transmission

Organism
— Varicella-zoster virus

Transmission
— direct contact, droplet or airborne spread of secretions of respiratory tract of intected persons
— indirect through articles freshly soiled by discharges from vesicles and mucous membranes of infected persons

Incubation & Identification

Incubation 14-16 days

Identification
— abruptly with low grade fever, malaise, and rash

Rash

a) rapid evolution from macule through papule — vesicular — crusting (taking 6-8 hrs.)

b) centripetel distribution of lesions which appear in crops

c) presence of lesions in all stages in any one anatomic area.

d) eventual crusting of nearly all the lesions.
— In typical cases of chickenpox, three successive crops of lesions appear over a three day period.
— Lesions → crops which are ↑ concentrated on trunk area—more profuse on upper arms and thighs.

Diagnosis

1) Clinical-manifestations

2) Isolation of virus

3) Serologic tests

Treatment
— Symptomatic

— Calamine lotion

Immunization
— Gamma Globulin to modify disease to special high risk persons.
e.g.
1) children with blood dyscrasias
2) infants under 1 month of age

— permanent immunity having had disease

Nursing Management
— Isolation (home)

— Transmission to others from approx. 1-5 days before onset of rash until all the vesicles have become dry.

— ASA for fever

— Cut fingernails so won't scratch lesions. (scratching causes scarring)

Complications
1. 2nd bacterial infection (Strep or Staph)
2. Encephalitis
3. Varicella Pneumonia
4. Varicella Hepatitis

Diphtheria

Causative Organism & Transmission	Incubation & Identification	Diagnosis	Treatment	Immunization	Nursing Management	Complications
Organism diphtheria bacillus (Klebs-Loeffler bacillus) *Transmission* — by direct or indirect contact — droplet infection — organisms present in saliva and nasal discharges of patients and carriers.	*Incubation* usually from 2-6 days *Identification:* — onset insidious with fatigue, malaise, sore throat, fever — bacillus causes acute inflammation of pharynx — secretion of toxin that irritates the tissues → fibrinous exudate that coagulates into a tough, leathery, grayish-white "pseudomembrane" — not always present or typical in color or consistency — this membrane could occlude air passages — cervical adenitis occurs — extensive swelling of the neck (bull-neck form) is possible — membrane could form in larynx — respiratory embarassment	1. Signs and symptoms. 2. Throat and nasal cultures.	— antitoxin — toxoid to immunized contacts — antibiotics	— D.P.T.P. — newborns have passive immunity for 1st year of life — *Schick* test for determining presence or absence of significant antitoxin	— strict bed rest, flat, turn q4h — only essential nursing procedures to decrease exertion on the part of the patient — isolation — room well-ventilated with fresh air — pulse, respiration and BP checked during administration of antitoxin — epinephrine and hydrocortisone kept for emergency use — tracheotomy tray, oxygen & suctioning — Tq4h, P & R q1h — saline mouthwash — warm throat irrigations — ice collar — I & O — fluids p.o. or I.V. — D.A.T. — observe for respiratory difficulty	1. Myocarditis 2. Paralysis of soft palate 3. Respiratory paralysis 4. Nephritis 5. Paralysis of ciliary muscles of eye, pharynx, larynx, or extremities

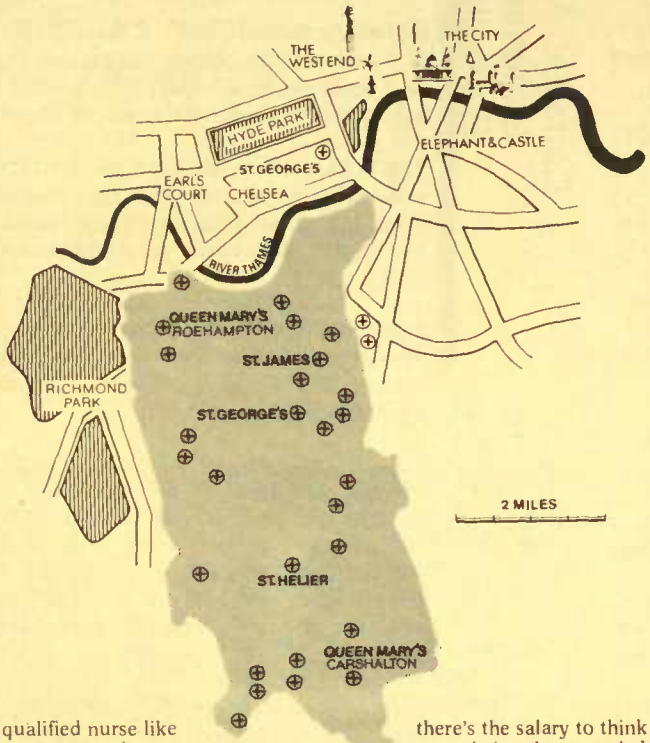
Smallpox* (Variola)

* provided for information only

Causative Organism & Transmission	Incubation and Identification	Diagnosis	Treatment	Immunization	Nursing Management	Complications
Organism Poxvirus Variola *Transmission* — direct & indirect contact — Airborne — Infected dry crusts — source of infection	*Incubation:* 12 days Identification: — 3-4 days prodromal period — Chills (children convulsions) — ↑ T (above 40° C) — Backache — Headache — Vomiting 3rd or 4th day — ↓ T and eruptive stage begins — Lesions a) move through macular → papular → vesicular → pustular → crusting stage b) appear on mucous membranes of mouth, throat and respiratory tract c) have a centrifugal distribution, and lesions in any one regional area are in same stage of development d) First appear on face and forearms and then spread to upper arms and trunk, particularly back and finally reaches lower extremities during pustular stage; ↑ T and the constitutional symptoms return after 2 weeks — complete epithelial regeneration (some scar formation)	1. Clinical manifestations 2. History 3. Acutely ill toxic person 4. Biphasic curve 5. Local eruption 6. Serologic tests	— usually started at beginning of pustular stage — penicillin or tetracycline — supportive therapy — parenteral flds. — eyes cleaned c̄ N/S	— active immunity by having disease — active immunity by vaccination at 12 months then every 6 years (not done if eczema present)	— Hospital — rigid isolation — Feeding by gavage — Eye care with normal saline — Oral and nasal discharges burned — Isolation — until scabs have disappeared — (Contact local health)	1. Impetigo 2. Furuncles 3. Cellulitis 4. Pneumonia 5. Septicemia 6. Osteomyelitis 7. Septic Arthritis 8. Laryngeal Edema

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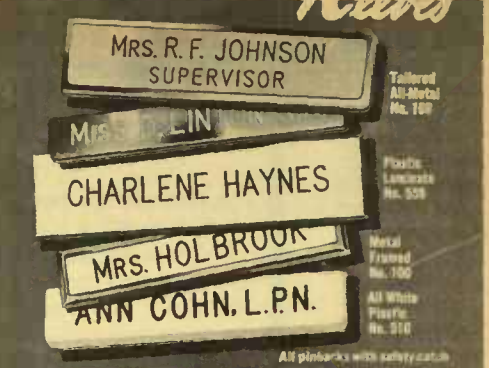
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Canadian Nurses' Association Statement on Accreditation of Education Programs in the Health Disciplines

The Canadian Nurses' Association believes that a national program for coordinating accreditation of educational programs in the health disciplines would be in the best interests of the public and the health professions.

The Association therefore supports the establishment of a national committee/agency to coordinate the accreditation process being carried out within each health profession and to provide the necessary liaison among all of the professions, agencies and institutions involved. The Association considers it essential that the national body charged with this responsibility:

I be broadly representative of the health professions, the government and the general public;

II be given clear and specific terms of reference regarding the provision and evaluation of the service; and

III be encouraged to act with all possible speed.

Terminology

The distinction between approval and accreditation has a direct bearing on attempts to evaluate health sciences education programs in Canada. It is imperative that all of the health sciences reach a consensus on the usage of these terms before proceeding with the development of accreditation programs.

CNA statements and papers on the subject are based on the following definitions:

I Approval

Approval means that a health education program has met the prescribed minimum standards set by the appropriate provincial body. Approval is compulsory and is based on minimum standards designated in Provincial acts or regulations authorized by these acts.

These standards usually include preparation and size of faculty, the nature and content of curriculum, the quality and type of clinical practice areas and administrative practices and control. This process is deemed necessary for the good of the public or, as it is usually expressed, "to protect the public from incompetent practitioners."

II Accreditation

Accreditation means evaluation and recognition of a program of education according to a national voluntary program.

Nursing Education Programs

I Approval

The process of approval has gone on for more than 50 years in schools of nursing in all provinces. Only graduates of approved schools are eligible to write registration examinations, and only graduates of approved schools who meet all other requirements, are eligible for provincial registration.

II Accreditation

At present, there is no national voluntary accreditation program of schools of nursing in Canada. There is, however, a commitment on the part of CNA to pursue this program in collaboration with all appropriate organizations. The principle of national voluntary accreditation was approved by the Association in 1945. This commitment still exists today.

Canadian Nurses' Association Statement on Nurses and Health Promotion

CNA believes that nurses are responsible for maintaining and improving their own health. At the same time, it is the collective responsibility of members of the nursing profession to do all they can to maintain and improve the health of their clients. The practice of nursing carries with it an obligation to improve the level of well-being of each client by responding to the immediate needs of the sick and disabled, by preventing illness and by promoting health.

CNA regards health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity," the definition endorsed by the World Health Organization.

Corollary Action

I Nurses can help to reduce self-imposed and environmental health risks among the general population through their example and actions.

This implies the choice of a lifestyle which maximizes well-being; the evaluation of current patterns of living in the light of their potential risks to health; and, as far as possible, the avoidance of self-induced risks and disease.

It also implies that education programs in nursing will integrate these concepts into their programs and that working conditions of nurses are consistent with the maintenance of health.

II As practitioners in health promotion and disease prevention programs, nurses need to establish constructive partnerships with their clients as well as with other health and allied practitioners. In order to be effective, it is important that nurses know what community resources are available and what assistance their clients can obtain from other health and allied professions.

This Association sees the need for more effective utilization of available nursing manpower to promote health among school children, industrial workers and the aged.

III Health promotion is also an important aspect of caring for the sick and disabled. During an illness, many patients are unusually receptive to suggestions for improving the level of their health. A nurse has more contact with the patient, his family and friends, over a longer period of time, than any other member of the health team. The ability to utilize this receptiveness and relationship is an important aspect of nursing practice. It is essential that nurses recognize the needs of the patient and his family and use these opportunities to assist them, both from the nurses' own resources and through referral to the appropriate agency.

October, 1975

At the last meeting of the CNA Board, directors approved two official position statements — one on health promotion and another on accreditation of health sciences education programs — as these issues affect the nursing profession. They bring the total number of official CNA statements to 15. These statements cover a wide range topics — from the expanded role of the nurse, to immigration and employment of nurses from abroad. Any reader may obtain copies by writing to CNA.

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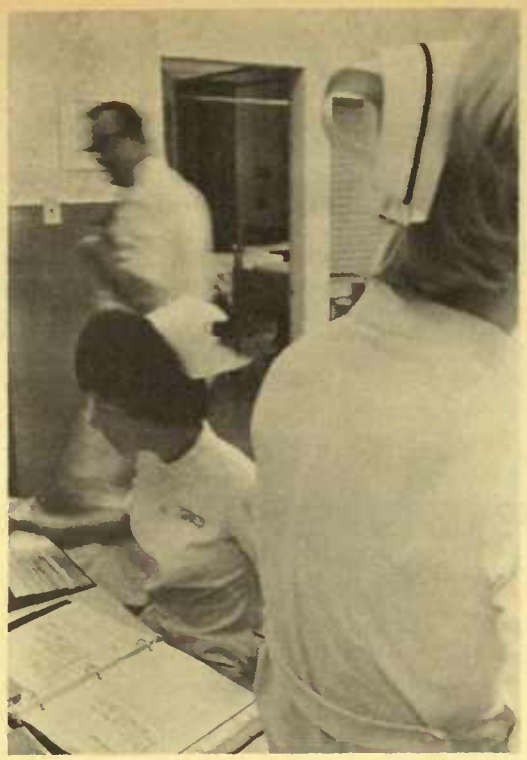
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Edited by Janet A. Williamson, Ph.D., R.N.; with 18 contributors. February, 1976. Approx. 208 pages, 6¾" × 9¾", 12 illustrations. Price: about $11.05 (clothbound); about $7.90 (paperback).

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Edited by Barbara Holz Peterson, R.N., M.S.N. and Carolyn Jo Kellogg, R.N., M.S.; with 26 contributors. February, 1976. Approx. 232 pages, 6¾" × 9¾", 2 illustrations. Price: about $11.05 (clothbound); about $7.90 (paperback).

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These original articles present new attitudes toward the roles, theories and tools in pediatric nursing. Part I discusses infant day care, transcultural nursing, etc. Part II emphasizes family needs during fetal development and early childhood. Current concepts and methods of nursing care of children with special problems are presented in Part III.

Edited by Patricia A. Brandt, R.N., M.S.; Peggy L. Chinn, R.N., Ph.D.; and Mary Ellen Smith, R.N., M.S. February, 1976. Approx. 240 pages, 6¾" × 9¾", 13 illustrations. Price: about $11.05 (clothbound); about $7.90 (paperback).

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Research

Bajnok, Irmajean. *A comparison of the quality of care provided by registered nurses working the twelve-hour shift and those working the eight-hour shift in a large general hospital.* London, Ont., 1975. Thesis (M.Sc.N.) U. of Western Ontario.

Within an 18 months' period almost all registered nursing staff at University Hospital, London, had voluntarily commenced working the 12-hour shift. Although the implementation of the 12-hour shift on each nursing unit was carefully controlled, there was some concern about the quality of care that could be provided by nurses working this shift. This study was undertaken to compare the quality of care provided by registered nurses working the 12-hour shift and those working the 8-hour shift at University Hospital.

Three criteria were used to measure the quality of care provided by registered nurses on the only remaining 8-hour unit and a comparable 12-hour unit in the hospital. The criteria used were implementation of the nursing process, attitudes of nurses toward nursing and nursing care, and attitudes of patients toward the nursing care provided. Three hypotheses stating there was no significant difference between the 2 units with respect to the above aspects of quality of care were tested.

The methodology included an audit of nursing records, and the administration of questionnaires to all registered nurses and 20 patients on each unit.

In all cases, the null hypothesis was rejected if $p = .05$ or less, using a 2-tailed test. The test of significance used was the sign test. All 3 null hypotheses were accepted, indicating that there was no significant difference in the quality of care provided on both units.

Some findings of particular relevance are:

1. Twelve-hour nurses maintained more complete records and were more knowledgeable about patient details and more satisfied with the quality of care they were able to provide than 8-hour nurses.
2. Attendance at inservice programs and awareness of program scheduling was a greater problem for 12-hour nurses than for 8-hour nurses.
3. Written evidence of nursing assessment and planning was generally minimal on both units, however, slightly more prevalent on the 8-hour unit.
4. Patient responses, although generally positive, tended to favor the 8-hour nurses.

Although the results were not overwhelmingly in favor of the 12-hour shift, it was concluded that it is reasonable to assume that the quality of care will not be adversely affected when nurses work a 12-hour shift.

Bain, H.W.; Cahoon, M.C.; and Jones, P.E. *An educational programme for nurse practitioners, 1972-74.* Toronto, Ont., 1975. Report, U. of Toronto.

This report documents the experience of a 3-year joint project of University of Toronto Faculty of Nursing and Faculty of Medicine and supported by National Health Grant No. 606-22-32. The aim of the project was to improve health care services through increasing the skills of nurses in primary care services.

The methods designed to achieve the objectives consisted of a 4-month continuing education program, offered 6 times during the period of the project; the series of programs was arranged in 3 phases of approximately one year, each to build on accumulating experience. Registration in Phase 1 was limited to applicants from Medical Services Branch, Health and Welfare Canada. In Phase 2, admission was broadened to include nurses from other primary health care settings. Phase 3 was designed to continue refinement of curriculum developed in Phases 1 and 2, and admission requirements were as for Phase 2.

Evaluation measures focused on the level of achievement of educational objectives, the level of graduate performance, peer acceptance, and job satisfaction. Methods included written tests, assessment of student clinical performance at specified intervals, and questionnaires to graduates and employers one year post-course. Instruments were developed for use by physician and nurse evaluators in judging pre- and post-course performance in a number of activity areas. Scores, based on the satisfactory ratings, were then derived.

Fifty-one students enrolled in the program during the 3 years under study; 21 of this total came from Medical Services Branch and the other 30 from a wide variety of primary care settings, largely urban. The educational background of students and the year of initial graduation varied greatly.

Student performance was demonstrably improved post-course compared to pre-course. This level of satisfactory performance appeared to be maintained, as judged by physician and nurse assessors, 6 months after completion of the course. Data from questionnaires one year post-course will not be complete before spring of 1976; plans are made to complete this phase of reporting at that time.

Based on the experience of the project and on current developments related to nursing in primary care, the report recommends that the educational program continue for the immediate future and includes a number of other related recommendations. It urges further investigation of such matters as outcome for nursing care and development of standards for primary health care.

Tubman, Norma Helen. *Nursing and related needs of young adults with post-traumatic, spinal cord lesions in the home.* Toronto, Ontario, 1975. Thesis (M.Sc.N.) U. of Toronto.

Twenty-seven post-traumatic, spinal cord lesion patients between the ages of 18 and 30 years were interviewed in this descriptive study. The primary purpose of the study was to identify and describe the expressed and observed nursing and related needs of these patients. The ultimate purpose was to improve the quality of nursing care for these patients in the home.

A structured interview schedule was developed to identify nursing and related needs in the following major areas: medical and nursing, psychosocial, educational, vocational, and environmental. The sample was obtained from a rehabilitation center and an official public health agency.

The findings showed that the largest number of expressed and observed needs was in the medical and nursing area. The areas of teaching most frequently needing improvement were identified as: prevention of urinary infections, prevention of pressure sores, and implementation of an exercise routine. Although the majority of the respondents appeared to be well adjusted to their injury, some psychosocial needs were identified. These needs were related to sexual information, emotional feelings, home arrangements, and marital problems.

No needs were identified in the areas of education, vocation, or environment at this time although, previous to the interviews, some changes had been made in these areas. Other needs identified were related to the patients' initial discharge to their homes and included adjustment to the family, adjustment to being in a wheelchair in the community, and not being able to perform household maintenance tasks.

The suggestions made by the respondents for improving treatment and services were: improved public facilities; increased public awareness of persons in wheelchairs; increased emotional, sexual, and marital counseling; better qualified and trained health professionals; family-centered nursing care, including counseling; integration of community resources; and improved training and placement services.

Although these patients with spinal cord lesions functioned relatively well in the home, findings suggest a need for continuous assessment and planned follow-up if they are to attain a high level of self-care.

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Books

The Right Combination: A Guide to Food and Nutrition by Elizabeth Chant Robertson. 180 pages. Toronto, Gage Educational Publishing Limited, 1975.
Reviewed by Elizabeth Lambie, Assistant Professor in Nutrition, School of Nursing, Dalhousie University, Halifax, Nova Scotia.

Hurrah, here is a perfectly delightful book on nutrition. The cover is attractive, the photography is exciting and some of the pictures stimulate one's digestive processes inadvertently. It is a book on food, written for Canadian students practicing and studying in Canada. The Canadian Dietary Standard, Canada's Food Guide, and information from the first reports of Nutrition Canada — National Survey are used in this edition of nutrients, foods and meals.

If you are going to be a professional nurse in Canada and you are giving applied nutrition information to a client it is recommended that Canada's Food Guide be the directive and not that of another country. The use of the information fabric in this text will prevent our nutrition standards from being lost.

Teachers of different levels and types of students will discover that the variety of methods of content presentation are beneficial, e.g. the practical test of materials related to the text, questions following each chapter to allow students to test themselves, the crossword puzzle, the reference list of films and publications, and summaries itemized at the side of the page for the working value of each nutrient.

This book is a mixture of the science of nutrition and applied nutrition. There are pertinent comments on income variations and misinformation and how these may affect eating patterns (a reference copy could be used in every Public Health Nursing office). Many faddist beliefs on food are given simple, correct, and scientifically supported explanations. The author is always gently nudging the "health food addict" and "crash dieter" with sound information in a matter-of-fact manner.

Following a detailed discussion on milk, its chemistry and even the so important cooking instructions the author writes "about the beginning of this century, yogurt. . . was hailed as a valuable health-giving food. Actually, it has no special virtues beyond those of 2-percent milk or buttermilk."

Many Canadian authors are praised for "their Canadian content" and I praise Dr. Elizabeth Chant Robertson because this is a well-written, refreshing book on a subject we all participate in three or more times daily — so, we are, you see, all experts in criticizing nutrition texts!

Maternal and Child Nursing, by Janice L. Goerzen, and Peggy L. Chinn. 210 pages. St. Louis, Mosby, 1975.
Reviewed by Margaret Armstrong, Teacher, Health Sciences Division, Humber College, North Campus, Rexdale, Ontario.

The intent of this book is to provide a concise and brief summary of maternal and child nursing, useful to students and graduates of nursing.

The book has 11 chapters and is presented in a question and answer format. Pertinent information about the family, human sexuality, contraception, abortion, and adoption is included in the first two chapters. Using the heading, "Nursing and the Growth and Development of Individuals," normal pregnancy and the care of the normal child through adolescence is presented. There are five chapters on high risk pregnancy and care of the child at risk through adolescence. Although the sequencing of the chapters does not follow a traditional pattern, one can easily find the content by review of the table of contents, or the excellent index.

In each chapter, questions or problems are presented in bold type followed by easy-to-understand, concise answers. The choice of the questions or problems appears to be those commonly encountered by a nurse and the answers, although brief, are accurate. Factual information as well as nursing action is included and an up-to-date list of references is available at the end of each chapter. Tables offer further detail in some content areas.

This book should prove useful to the nursing student as an adjunct to her prescribed texts both in the learning of new content as well as in review. Nursing personnel in the clinical areas should find this book helpful for quick reference.

Textbook of Anatomy and Physiology (9th edition) by Catherine P. Anthony, and Norma J. Kolthoff. 597 pages. Saint Louis, The C.V. Mosby Co. 1975.
Reviewed by Marilyn Bowers, Humber College, Osler Campus, Weston, Ont.

Textbook of Anatomy and Physiology, already familiar to many nurses, is an excellent book used in several diploma schools of nursing. The ninth edition is updated to comply with recent research and reorganized to give the contents better continuity. Reproduction is reorganized into three chapters: Cell Reproduction, Female Reproduction and Male Reproduction. The Nervous system is also presented in three chapters and a new chapter has been formed in Metabolism. Throughout the book, the tables and diagrams have been correlated more closely with the text.

Appropriate additions, revisions and deletions have been effected. Revised subjects include: functions of the skeletal system, functions of the muscular system, functions of the liver, the physiology of the nerve synapse, mitosis, meiosis, and glycolysis. The metabolism of vitamins, minerals and water has been deleted, whereas biofeedback, the electrocardiograph, oogenesis, and spermatogenesis have been added. Stress is presented in two chapters, one discusses Hans Selye's concept of stress and the second, the current concepts.

In any book which covers such a potentially large subject as human anatomy and physiology the authors face the decisions of what to include, omit, where to elaborate, and condense. In many sections the authors have found it necessary to condense and simplify complex concepts. For nurses who wish further understanding of these concepts supplementary readings have been listed for each chapter.

The emphasis throughout the textbook is on physiology and function. Anatomy is covered adequately and the accompanying illustrations are excellent. Nurses may, at times, require further elaboration of some anatomical details, e.g. the spleen.

For anatomy and physiology courses taught in current nursing diploma programs, this book provides a valuable resource to which the student may refer as she progresses.

The ninth edition of *Textbook of Anatomy and Physiology* updates information and the content has been reorganized to give better continuity. This is an excellent textbook for nurses studying anatomy and physiology.

System of Nursing Practice, A Clinical Nursing Assessment Tool, by Eileen Becknell and Dorothy M. Smith. 176 pages. Philadelphia, F.A. Davis Company, 1975. Canadian Agent: Toronto, McGraw-Hill.
Reviewed by Joan Royle, Assistant Professor, McMaster University School of Nursing, Hamilton, Ontario.

The clinical nursing tool developed by Dorothy M. Smith is a guide for collecting and organizing data to be used in planning, implementing, and evaluating nursing care. It provides for standardization of data collection and a means of applying the scientific method to the identification and solution of nursing problems. The system of nursing practice described in this text is based on the nurse-patient relationship and the use of the problem-solving process.

In the first section of the book, the authors discuss the purposes of the tool and provide background information on the problem-oriented system, as well as the theoretical concepts and skills necessary for the systematic collection of data. The second section is concerned with the process of clinical thinking used by the nurse to identify patients' nursing problems, develop a plan of care and evaluate the results of nursing care.

The book is well-organized, written in a straightforward style, providing simple step-by-step directions on how to apply the problem-oriented system

to nursing practice. The examples of each part of the process focus on clinical nursing situations making the context and its application more meaningful to nursing care.

All nurses can benefit from this excellent text that gives meaning and direction to nursing care activities and insight into the thinking processes involved with the identification and management of nursing problems. As the authors state, this book would be especially useful for students and practitioners of baccalaureate programs and would be a valuable reference for nurses in institutions using problem-oriented records.

Death The Final Stage of Growth, by Elisabeth Kübler-Ross. 175 pages. Englewood Cliffs, N.J., Prentice-Hall, 1975.
Reviewed by Marjorie W. Hayes, Project Administrator, Research Programs Directorate. Health and Welfare, Canada, Ottawa.

Death is an integral part of our life whether we accept it or not, and Kübler-Ross assists each reader to face this issue. The reader is constantly reminded of how society rejects death and its finality and how important it is for each person to face it and cope with it.

The author selected a number of writings concerning individual experiences of death and drew them together to tell a story of life. Through the experiences of others, as well as herself, we are exposed to the thoughts of death by different religions, creeds, myths, and mysteries. In philosophy, literature, and art we are also shown that death inspires great work. Traditions play a vital role in the expression of grief and the acceptance of the loss.

The greatness of this work is to remind each reader of his past in the dying process. Over and over again Kübler-Ross makes it clear that one's role must be *ACTIVE* in the dying and death process. The recognition of death is necessary for a whole and full life.

The description of "Old Sarah" planning and predicting the day of her death is a moving and heartwarming instance. The entire community participated in the funeral arrangements and shared in her peaceful rest. Audrey Gordon's description of America "The death-denying society" is startling, but helpful in understanding the reason for denial and dishonest communication. Raymond Carey's description of the "Living until Death Program" shows the problems in instituting change by means of a program. This section is of special help to the nurse.

The summary of the findings assists the nurse to face questions of great relevance in the care of patients and in helping her to face her own questions. I am convinced that each nurse who reads this section attentively will be able to face the emotional adjustment of dying and death. Each will understand how to deal with her own feelings and senses.

"Death and Growth: Unlikely Partners" written by Kübler-Ross shares her personal experiences with death. She shares the desire to avoid death and how one can gain valuable growth in accepting it. She assists each reader in assessing his individual honesty concerning communications with the dying. This area of the book is especially useful to those in psychiatry or nursing who have experienced the dying patient or to those who have grieved a loved one.

Thinking about one's own death is very traumatic, especially for those who have been shielded from this agony by society, family or self. This book will assist the searcher to experience the meaning of life in finding the reality of death. Death is a problem in our society because we refrain from facing it. In reading this book each nurse will be challenged to deal with the problem and in the solution each will find a peace never before known.

Library Update

Publications recently received in the Canadian Nurses' Association Library are available *on loan* — with the exception of items marked **R** — to CNA members, schools of nursing, and other institutions. Items marked **R** include reference and archive material that does *not* go out on loan. Theses, also **R**, are on Reserve and go out on Interlibrary Loan only.

Requests for loans, *maximum 3 at a time* , should be made on a standard Interlibrary Loan form or on the "Request Form for Accession List" printed in this issue.

If you wish to purchase a book, contact your local bookstore or the publisher.

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Library Update

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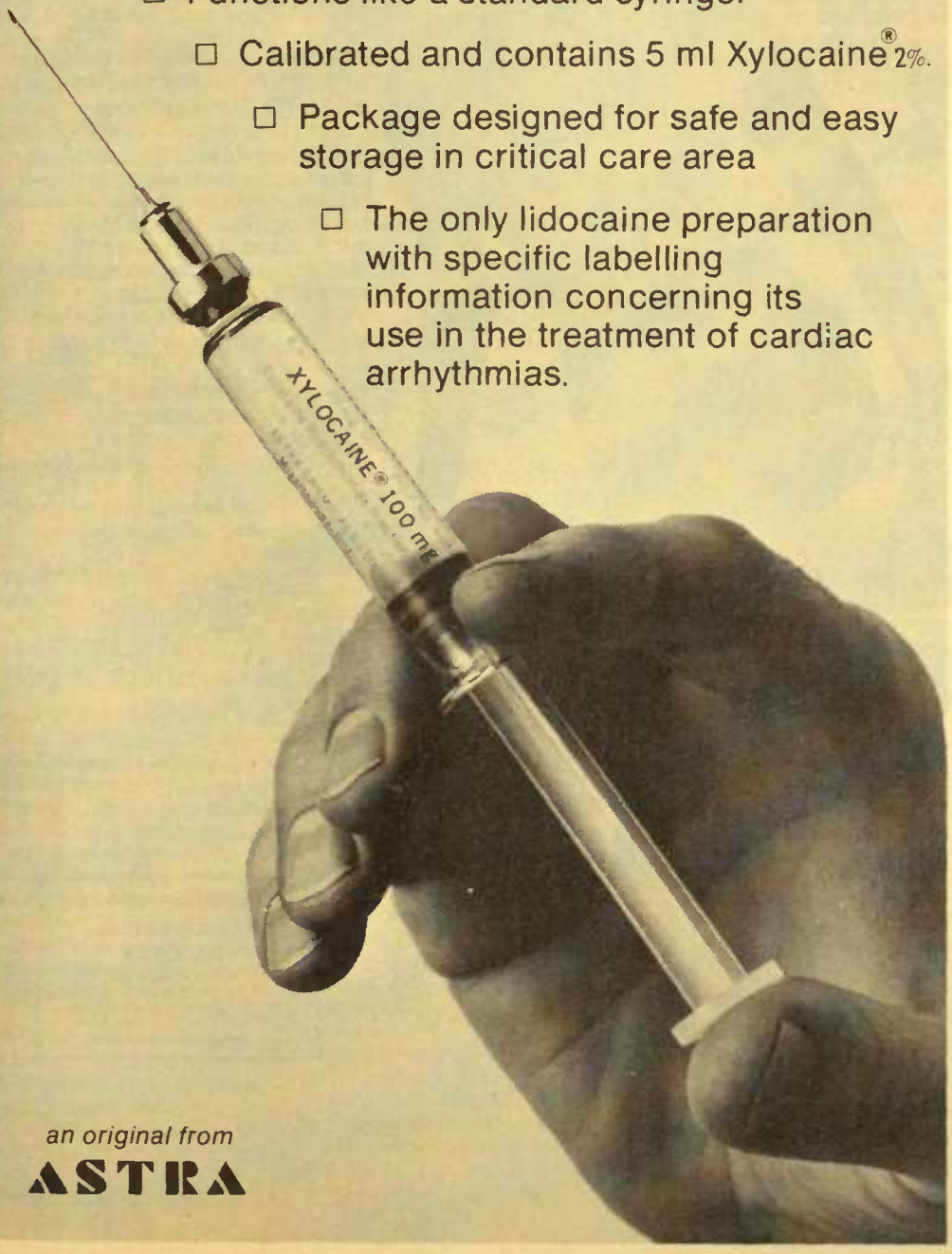
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WARNINGS—Constant monitoring with an electrocardiograph is essential in the proper administration of Xylocaine intravenously. Signs of excessive depression of cardiac conductivity, such as prolongation of PR interval and QRS complex and the appearance or aggravation of arrhythmias, should be followed by prompt cessation of the intravenous infusion of this agent. It is mandatory to have emergency resuscitative equipment and drugs immediately available to manage possible adverse reactions involving the cardiovascular, respiratory or central nervous systems.

Evidence for proper usage in children is limited.

PRECAUTIONS—Caution should be employed in the repeated use of Xylocaine in patients with severe liver or renal disease because accumulation may occur and may lead to toxic phenomena, since Xylocaine is metabolized mainly in the liver and excreted by the kidney. The drug should also be used with caution in patients with hypovolemia and shock, and all forms of heart block (see CONTRAINDICATIONS AND WARNINGS).

In patients with sinus bradycardia the administration of Xylocaine intravenously for the elimination of ventricular ectopic beats without prior acceleration in heart rate (e.g. by isoproterenol or by electric pacing) may provoke more frequent and serious ventricular arrhythmias.

ADVERSE REACTIONS—Systemic reactions of the following types have been reported.

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(2) Cardiovascular System: hypotension; cardiovascular collapse; and bradycardia which may lead to cardiac arrest.

There have been no reports of cross sensitivity between Xylocaine and procainamide or between Xylocaine and quinidine.

DOSAGE AND ADMINISTRATION—Single Injection: The usual dose is 50 mg to 100 mg administered intravenously under ECG monitoring. This dose may be administered at the rate of approximately 25 mg to 50 mg per minute. Sufficient time should be allowed to enable a slow circulation to carry the drug to the site of action. If the initial injection of 50 mg to 100 mg does not produce a desired response, a second dose may be repeated after 10-20 minutes.

NO MORE THAN 200 MG TO 300 MG OF XYLOCAINE SHOULD BE ADMINISTERED DURING A ONE HOUR PERIOD.

In children experience with the drug is limited.

Continuous Infusion: Following a single injection in those patients in whom the arrhythmia tends to recur and who are incapable of receiving oral antiarrhythmic therapy, intravenous infusions of Xylocaine may be administered at the rate of 1 mg to 2 mg per minute (20 to 25 ug/kg per minute in the average 70 kg man). Intravenous infusions of Xylocaine must be administered under constant ECG monitoring to avoid potential overdosage and toxicity. Intravenous infusion should be terminated as soon as the patient's basic rhythm appears to be stable or at the earliest signs of toxicity. It should rarely be necessary to continue intravenous infusions beyond 24 hours. As soon as possible, and when indicated, patients should be changed to an oral antiarrhythmic agent for maintenance therapy.

Solutions for intravenous infusion should be prepared by the addition of one 50 ml single dose vial of Xylocaine 2% or one 5 ml Xylocaine One Gram Disposable Transfer Syringe to 1 liter of appropriate solution. This will provide a 0.1% solution; that is, each ml will contain 1 mg of Xylocaine HCl. Thus 1 ml to 2 ml per minute will provide 1 mg to 2 mg of Xylocaine HCl per minute.

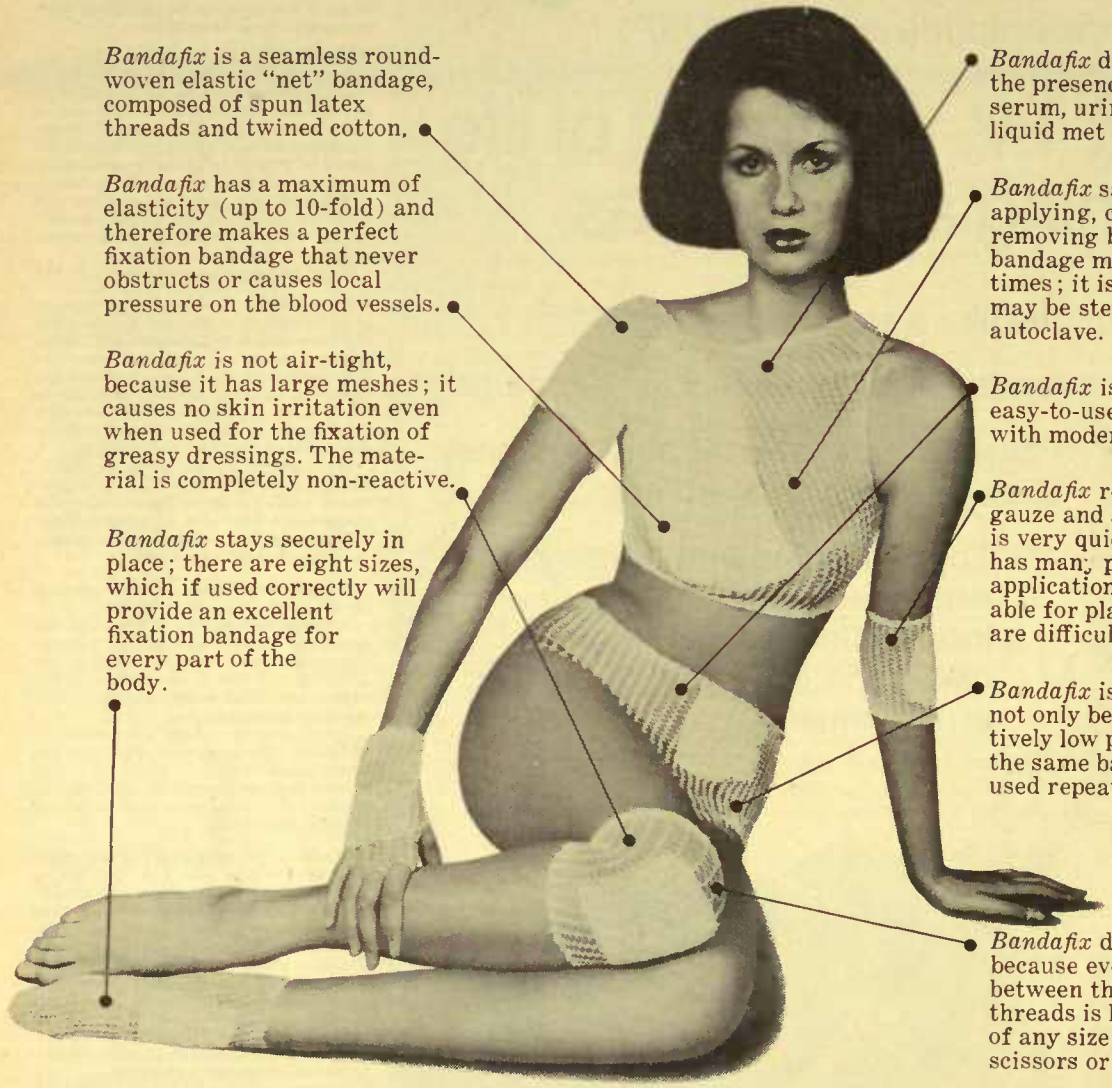
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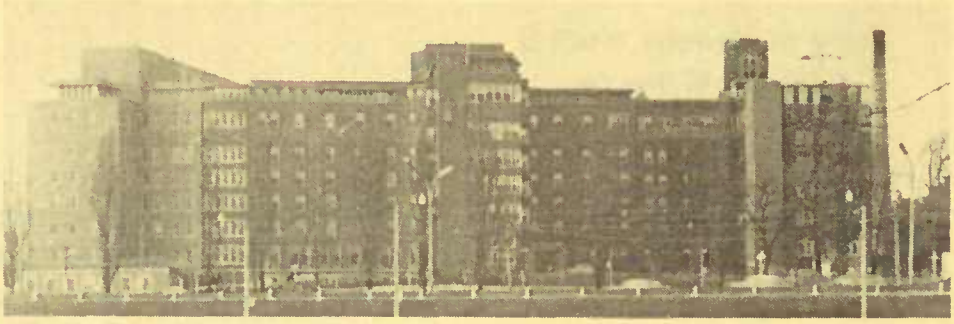


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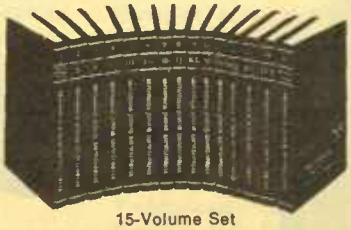


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"The Ups and Downs of Communication" are the subject of this month's forum, *Frankly Speaking* (page 13). Author, Lorine Besel asks: "Are we making the best use of our time with our patients? What effect do variations in eye level have on communications?" The photo illustration for this feature and the cover were provided by Health and Welfare Canada

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses' Association.

ISSN 0008-4581

Indexed in International Nursing Index, Cumulative Index to Nursing Literature, Abstracts of Hospital Management Studies, Hospital Literature Index, Hospital Abstracts, Index Medicus. *The Canadian Nurse* is available in microform from Xerox University Microfilms, Ann Arbor, Michigan, 48106.

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Perspective

A couple of books people are talking about these day, with titles that go a long way towards explaining their contents, are: "When I Say No, I Feel Guilty" by Dr. Manuel J. Smith and "Don't Say Yes When You Want to Say No" by Jean Baer and Dr. Herbert Fensterheim.

The subject of these books — assertion therapy or assertiveness training — is a behavior concept that gives everyone something to think about. In essence, it says that each of us has the right to express his own needs, convictions and *wants* openly, in a direct and positive manner. The underlying theory, and one with a certain irresistible logic, is that, if we communicate our needs and beliefs clearly and convincingly, they are more likely to be understood and respected than if we camouflage them behind a subservient or diffident "don't care" attitude.

The aim is *appropriate* expression of these rights as we see them. It does not imply angry or overtly aggressive attitudes. It *does* imply mutual respect and acceptance on the part of ourselves and our associates.

Assertion therapy presents nursing with some interesting conundrums. Already, many individual nurses— whether or not they have undergone formal training or read the books, have changed their professional attitude in response to this concept. These nurses have stopped saying "yes" to unreasonable demands and are, sometimes to their own surprise, saying "no" or at least "why?" They are finding that the self-confidence and self-respect they gain when they know their ideas and needs will be listened to, means that they can provide their patients with more appropriate care.

For years, nurses have been caught between two absolute and often opposing lines of authority — administrative and medical. Psychologists point out that when a person is constantly made to feel subservient and subordinate, without being allowed to express annoyance or anger, that person often vents his anger on unthreatening people in his immediate environment. It may not be *appropriate* to take out our frustration on a helpless patient but all of us have been tempted to do it.

What happens, though, if the majority of the nursing profession accept the need to assert themselves and to participate openly in decision-making? What will be the new rules for the "doctor-nurse game" that has not only allowed but even encouraged nurses to manipulate and wheedle the medical profession into making the decisions nurses wanted? Will nurses be able to establish new lines of communication and patterns of interaction with the medical profession and administrative hierarchy based on mutual respect and recognition of each other's talents? It's worth thinking about, isn't it?

— M.A.H.

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Photo by Gabor Szilasi

Next month *The Canadian Nurse* will feature a series of articles especially chosen to complement the work of nurses whose clients include mothers and their newborn offspring. Topics include a look at how drug use (prescription and non-prescription) affects lactation as well as a useful guide to helping new mothers establish a successful breast feeding routine.

The Canadian Nurse has joine a small but growing number of Canadian publications that are computer typeset. (Optical characte recognition is the name printers use In theory, elimination of the possibilit of human error at a certain stage o production could result in error-free copy. Sometimes strange and unpredictable things happen howeve and this month's copy included several paragraphs that looked like this:[1] o– *T*↑... ——.....–– *VY*%.....–%*j* [5]__% @#*ı*{_ ⟨‰↑%c⟩ *V*↑] *W*# · ↓%*T* ↑}%‰ *ß*__% *Y*....[– *T*↑...¡ %*ß*{¡ %*ß*{ %*ß*{¡ /↑%*ı*__ *ß*__% *Bı* · % *V*↑‰ ....*Y* ...↑↑*T* ·%⟩ ....⟩*T* %↑·%⟩ *ß*↑ {↑·% *ß* *ß*__% ...*JT* ↑*V ß*__% [0]‰↑...‰%–––*ı*}% *π*↑⟩––%‰}...*ßı*}%––*j*

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Input

Nursing In Quebec

In *Quebec Nursing Shortage Not Due to Immigration* (October, 1975) I am quoted as saying:"The shortage is more acute in other countries than in Quebec. Canada will have to train more nurses." Actually, I said:"If it was proven that we have not enough nurses to give the nursing care required by the population, Canada will have to train more nurses."

In the paragraph regarding Bill 22, you said that the bill will apply to Canadian nurses *from other provinces* as of July 1st, 1976. This is not correct. As of July 1st, 1976 the requirement of a working knowledge of the French language (Bill 22) will apply to *all* nurses from other countries, other provinces, or from Quebec.

Also, you state that after the temporary permit has expired, nurses will not be allowed to practice in Quebec without a certificate. This is not clear. After the expiration of the one-year temporary permit, a nurse, to be recognized and qualified to practice in Quebec, must obtain a certificate attesting that she has a working knowledge of the French language.
Gertrude Jacobs, N., B.N., Registrar, The Order of Nurses of Quebec.

Sex Talk and Nursing

One of your respondents (Letters, Sept. 1975) mentioned a program, Human Sexuality and Fertility, conducted by McMaster University in Hamilton as one with which she was familiar, and she encouraged the development of other similar courses.

I want to inform your readers of another program that is currently in its second year of existence. Conducted by the Health Sciences, Continuing Education Division of Algonquin College, in Ottawa, the program is 360 hours in length extending on a part-time basis from September to April. It is multi-disciplined with all students holding a previous diploma or degree in nursing, social work, theology, education, counselling, and related areas.

As human sexuality is a relatively new educational area I strongly feel that those of us involved in teaching it should be aware of what others are doing so that we can share and constantly improve our programs. If any of your readers wish further information about our program, I would be most pleased if they would contact me.

My sincere thanks to *The Canadian Nurse* for publishing the original article "Sex Talk and Nursing." Hopefully, it will stimulate nursing educators to implement courses in sexuality in basic nursing programs.
Lorraine Hill, R.N., Algonquin College, Continuing Education, Health Sciences, 2135 Knightbridge Rd., Ottawa, Ont.

A description of this course offered by Algonquin Community College was also sent to the editor by Rosemary McDonald, B.S.N., Ottawa.

Editor's Note: "Sex Talk and Nursing," (June 1975), the first forum written by CNA member-at-large, Lorine Besel, deserves critical acclaim for its long-term box office appeal. Responses to this column continue to reach both the author and editor. Although we appreciate your interest, the author is concerned about the possibility that other significant issues are being overlooked. She asks that you express your convictions through positive action rather than further correspondence on this subject.

A Liberated Male

I find it rather ironical that some of your authors, who profess to be feminists, commit a self-defeating error in their efforts to bring equity to women. I refer specifically to the use of the gender"she" or "her" in making general statements about nurses. All nurses are *not* female. Believe it or not — there are male nurses in the world.

Men need liberation too. We must be conscious of these subtle discriminatory addresses if women are to really gain social equality, instead of becoming female chauvinists.

May I suggest to potential future authors the use of "the nurse" or he/she after the person in the article has been identified by their full name.
Christopher Lemphers, R.N., Old Masset, B.C.

A Pat on the Back

The article *Caring for the Untreated Infant* (December 1975) proposes an approach to a problem that many nurses have faced. The author comes to grips with the basic question of how a nurse is to care for an infant that others have decided is to die. This is a situation that faces nurses regularly and one for which nurses have been ill-prepared. Young students find this situation of "letting a baby die" basically opposed to their personal value system and what is taught them in nursing. Colleen McElroy has written the definitive paper on the subject. Her concern for life and her commitment to nursing as it should be practiced are impressive. She should be awarded the gold star for excellence.
Eileen Mountain, executive secretary, Canadian Association of University Schools of Nursing, and assistant to the secretary-treasurer, Canadian Nurses' Foundation.

Nursing Heritage Preserved

A year ago you published a letter in which I explained my concern that no archives in Canada was assembling a collection of material that would tell future generations the story of the nurse in the north. Since that time, I have worked toward the establishment of such a collection and feel that many of your readers would be interested to know of the work being done.

In cooperation with the archives of the Glenbow-Alberta Institute, an eight-part documentation has been established. It consists of: 1)original writings (that is, letters or diaries) 2) written reminiscences; 3) copies of short published writings; 4) photographs; 5) documents and memorabilia; 6) taped interviews; 7) a bibliography of major published works; and 8) a cross-indexed file of resources. Readers who wish to contribute material to this collection should contact me. Items need not be permanently relinquished but will be photocopied and returned if the owner so requests.

This fall I received a Canada Council grant to continue my work on the collection and expand the taped interview section. I am currently assembling names of nurses with northern or early frontier experienc who might be considered suitable interview subjects. I would urge any your readers who have had this type experience and would agree to an interview, to contact me as soon as possible.
Joy Duncan, R.R. 3, High River, Alberta, T0L 1B0.

Primary Care Practitioners

We are a group of Nurse Practitioners working in primary car settings, who have formed an interes group, with the intent of sharing an seeking solutions to common problems, and adopting unified tern of reference.

We are interested in hearing fro other similar groups across Canad regarding membership, function, ar the problems they have faced and solved since being in existence.

Please contact Margaret Nixo c/o Klinic Inc., 567 Broadway, Winnipeg, Man. R3C 0W4. —
Margaret Nixon, Nurse Clinician, R.N., S.R.N.

Comprehensive Care Model

The article *Nurses and the My of Full Employment* (September 1975) has stirred my interest. It is a fact that the health care delivery structure is changing. As hospitals change, nurses must also change, and the central problem is whether nurses can change appropriately. I found it disappointing that Monagha would suggest nurses use their background as a basis for moveme into administrative support service positions. Granted, we will need administrative support — but these people do not need to be nurses. Th shift from training in a hospital for a specific role within that organization t education in an institution of higher learning, has already suggested a broader role. The nurse of the futur must be a practitioner of the science o nursing, and be prepared to care fo people in whatever setting they are found.
James D. Parsek, R.N., Instructor Nursing, The University of Wisconsin/Milwaukee, Milwaukee, Wisconsin.

Send for the recipe.



An important study of a nutritious diet designed to reduce serum cholesterol.

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News



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Blueprint Committee Studies Comprehensive Exam

The dream of a comprehensive examination for all Canadian registered nurses is a step closer to realization after two recent planning meetings in Ottawa. The "Blueprint Committee on Comprehensive Examinations," set up by the CNA Testing Service, met at CNA House in November and January for a total of eight days to begin work on a bilingual blueprint for a Comprehensive Examination for R.N.s that should be ready for use by 1978.

The blueprint is based on a conceptual model developed by the *Ad Hoc Committee on Comprehensive Examinations* and accepted in June 1975 by the CNA Committee on Testing Service. The new examination will emphasize a general, multidimensional approach to nursing, rather than using a variety of tests to measure knowledge of specific clinical areas. This change reflects the shift to more integrated nursing education programs across Canada, and will result in an examination more closely attuned to the "real" world of nursing.

The Committee is composed of four French and four English-speaking members. Pictured above during the most recent meeting of the committee in January, are (left to right) front row: Denise Dionne. Montreal; Helen Evans, Willowdale, Ontario; Myrtle Kutschke (chairman) Sudbury, Ontario; Margaret McCrady, Winnipeg; back row: Claire Kermacks, Vancouver; Michelle Charlebois, Montreal; and Velma Wade, Moncton. Absent for the photo was Madeleine Corbeil of Montreal.

Further information about the work of the Blueprint Committee and the development of the Comprehensive examination will appear in future issues.

Manitoba Labor Group

A new independent labor organization called the Manitoba Organization of Nurses' Associations (M.O.N.A.) has been established to replace the Provincial Staff Nurses' Council. Provincial bargaining units, now composed of 48 certified Nurses' Associations, are members.

Nurses' elected to the Provincial Staff Nurses' Council last May will finish their terms as members of the Executive Council of M.O.N.A. The President of the new organization is Shirley Codd of Winnipeg and the vice-president is Kathleen Connors of Thompson.

CNA Supports International Convention

The Canadian Nurses' Association has replied to a questionnaire on conditions of work and life for nursing personnel, prepared by the International Labor Organization. Results of the survey will be discussed at the 61st session of the International Labor Conference in Geneva in June, 1976.

Among suggestions proposed by CNA:

— the International Labor Conference should adopt an international instrument on the situation of nursing personnel;

— this instrument should take the form of a convention, rather than a recommendation;

— the instrument should apply to *two* levels of nursing personnel, the professional nurse and the auxiliary nurse, as described in the Report on the Joint Meeting on Conditions of Work and Life of Nursing Personnel sponsored by the International Labor Organization and World Health Organization.

Adoption of a convention based on the ILO - WHO report would involve both provincial and federal government in Canada since both levels of authority have jurisdiction over working conditions of nurses. CNA's response to the ILO questionnaire was prepared at the request of the International Council of Nurses by Glenna Rowsell (CNA member-at-large for social and economic welfare) and Margaret Wheeler, associate secretary and consultant in labor relations, Order of Nurses of Quebec. It was ratified by CNA directors at the October 1975 meeting.

An* Addendum *to the 1974 Edition of the* Index of Canadian Nursing Studies *is now available on request from the Canadian Nurses' Association. (Price $1.00) Both the 1975 addendum and the basic index were compiled by the CNA Library. The index update lists studies on which information was retrieved between July, 1974 and October, 1975. Copies of the basic index are still available at $5.00.

RNAO/CNA Launch Pilot Health Project

From January 20 to March 20, 197 CNA , in collaboration with the Registered Nurses' Association of Ontario will implement a health promotion pilot project at Toronto General Hospital. The project is aimed at raising nurses' awareness their own health standards and promoting changes in their lifestyle It will provide for the measurement the "health status" of individual nurses, using some of the tests demonstrated at the 1974 CNA convention in Winnipeg. Once thei present state of health has been determined, nurses will be given assistance to establish fitness programs that suit their individual needs. Provision will be made for continued follow-up of their progres This project is intended for use in in-service educational programs.



A report on the demonstration project will be made to the CNA Boa of Directors in February 1976. Directors will then consider extendi the program to other provincial nursing associations.

The plan is being implemented meet a directive from CNA members at the Winnipeg meeting "BE IT RESOLVED THAT CNA explore ways and means of developing a plan of action to sensitize or raise the level of nurse to lifestyles conducive to optimum health."

New B.C. Minister Explores Dimensions of Health Care

British Columbia's new health minister is sure there is an expanded role for nurses but not so sure how it can be developed. Six days after being named to the portfolio, Health Minister Robert Howard (Bob) McClelland, 42, admitted he is not "too familiar" with the expanded role program.

"I guess that's a subject for discussion with the doctors, too. I think the nurses in our community can take a much greater role in delivering health care to people, yes, and I'd like to see that happen."

Asked whether he sees this as a prerogative of the medical profession, he replied: "Well, I think that's why I'd have to talk to the doctors. I'm sure some of them think that it is. There must be areas where we can provide a cheaper form of care without endangering the patient. I feel that probably doctors don't know where to go on this one either."

McClelland said he could not express an opinion about apprenticeship training of licensed practical nurses, as it is being urged by the Hospital Employees' Union and opposed by the Registered Nurses' Association of B.C.

He said he has no plans to interfere with present legislation covering professional licensing bodies, but may extend licensing to other groups. Acupuncturists were the only example given.

Continuation of the public health nursing freeze, imposed by the former NDP government several months ago, depends on the extent of provincial financial problems, he said. "I don't like to see a freeze on essential services. I'm very surprised there hasn't been an uproar about it from the public health people." The freeze prohibits replacement of public health nurses or hiring of additional staff.

The former opposition health critic said it was too early for him to say whether B.C. will require a spending freeze similar to that imposed recently by the Ontario health ministry. Hospitals have been given financial restrictions "to live within their budgets" which "may in effect cause a freeze," he said. But he added, "hospitals are not doing this and there will be deficits."

There is a $17 million overexpenditure in hospital programs, for which funds are not available, he said, and medical services costs are over by about $47 to $48 million but these will be partly covered by $30 million in the Medical Commission reserve funds.

McClelland is a former moving van driver, broadcaster and publisher, and has served on the board of the Langley, B.C. Memorial Hospital. He became interested in health care while serving on a committee established some years ago by the former Narcotic Addiction Foundation in Vancouver.

RNANS Holds Workshop On Caring For Aged

"Old age is not a disease, it is something that comes to all of us," Frances Moss, Executive Secretary, RNANS, said in opening the association's recent workshop on new approaches to meeting the needs of the aged. "Old age can be a time of loneliness and depression, but it can also be a time of serenity and quiet joy. The difference is sometimes the presence of a caring nurse, a nurse like those of you here today who have come here because you are touched by the theme of this workshop 'Someone Like You'."

The workshop was open to R.N.'s and Administrators of Nursing Homes and Homes for the Aged. Nearly 70 people participated, the majority of them nurses from Homes for Special Care.

Shirley Campbell, Director of Nursing at Ocean View Manor and Chairman of the new RNANS Special Committee on Needs of the Aged, was general chairman of the workshop.

Anti-Smoking Group Appoints Executive Director

The Canadian Council on Smoking and Health, a national anti-smoking lobby group with headquarters in Ottawa, has appointed Kurt Baumgartner as Executive Director. Baumgartner was head of health science program development and, later, coordinator of allied health programs at Algonquin College in Ottawa.

The council is composed of national voluntary health organizations which share an interest in smoking and its hazards to health. Activities include examining legislative approaches intended to prevent smoking, publishing information on advances in related research, raising funds for research projects and disseminating technical data on smoking and its consequences.

CNA is represented on the 1975—76 Board of Directors of the Council by Jane Henderson, Associate Executive Director of the national nurses' association.



Did you know?

That nurses across Canada look to CNA for information on continuing education? In answer to these requests, CNA library staff maintains an up-to-date list of all short-term and non-degree courses available to graduate nurses across Canada.

This list provides information on title, duration, date, fee and location of the course as well as names of persons to contact for further information. It's available at no charge from the CNA library.

Community Nursing Course Offered By Correspondence

The first correspondence course in nursing to be offered at a Canadian university was developed in Saskatoon and is now under way. The course, a half-class in preventive health care, was prepared by the College of Nursing at the University of Saskatchewan and is available through the University's Department of Correspondence Courses. It will be followed by a full class at Intersession or Summer Session on community health nursing, during which the practical and clinical aspects of the nurse's role will be emphasized.

The package was developed for degree graduates in nursing whose undergraduate programs did not include a course dealing with preventive health care in a community setting.

Professor A. E. Caplin, of the College of Nursing, points out that in recent years there has been a growing emphasis on community nursing through public health departments and private agencies such as the Victorian Order of Nurses. In the College's five-year degree program, phased out in 1971, community nursing was an optional subject and some of the students, as well as some from other universities, graduated without experience in this growing field. As a result, they are at a disadvantage if they wish to seek community nursing positions in health regions or elsewhere.

The objective of the correspondence course is to help nurses understand their role in a changing health delivery system that is placing increasing emphasis on preventive health. Health requirements will be analyzed in terms of factors such as basic human needs, the environment and quality of life, disease and disaster.

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PROCTER & GAMBLE CAR-322

This month's forum has been submitted by CNA member-at-large for nursing practice, Lorine Besel, Director of Nursing, Royal Victoria Hospital, and Assistant Professor, School of Nursing, McGill University, Montreal.

Frankly Speaking about nursing practice

The Ups and Downs of Communication



Lorine Besel

Try this experiment. Take a friend home to bed. Distortions in experimental results may occur if one of you is male and the other female. There is experimental evidence that males tend to dominate conversations by the simple mechanism of using up the available speaking time. So, for the pilot project at least, let's stick to inviting the same sex as yourself to your bedroom.

Experimental Procedure

1 Keep reading. This is serious.

2 Choose agenda before adjourning to bedroom.

a) Social Agenda. Two topics such as books, movies, concerts which both have experienced.

b) Sickness Agenda. Two areas of poor health which are of concern to your friend e.g. headaches, constipation, sleeplessness, lost loves, whatever.

3 Have available a 3-minute timer and a recorder.

4 Have available a chair — to be used only as instructed.

5 Friend is to lie down on bed covered by blanket (patient role).

6 Have chair available near the bed and close enough to sit if you wish to do so. Start timer and tape recorder at beginning of each sequence.

7 Discuss one Social Agenda item for 3 minutes *while remaining standing beside the chair.* Note reactions in self and friend.

8 Discuss one Sickness Agenda item for 3 minutes *while remaining standing beside the chair.* Note reactions in self and friend.

9 Discuss one Social Agenda item for 3 minutes *while sitting down.* Note reactions in self and friend.

10 Discuss one Sickness Agenda item for 3 minutes *while sitting down* Note reactions in self and friend.

11 Variations on the experiment can include:

- wearing a uniform in one set of the Social and Illness Agendas, but not in the other.
- reversal of roles
- try the experiment in hospital with real patients and variations such as high or low beds, standing over sitting patient, or sitting beside sitting patient.

Observations and Reactions to be Recorded

Are there differences in the sense of comfort or discomfort experienced by each of you in relation to variations in eye level of communication between the sitting and standing positions? Does the length of time that each person speaks change as you sit or stand? Does the content of each person's speech change as you move from the sitting to standing positions? Does this vary equally with the Social and Illness topic, or do process and content vary more significantly with the topic than they do with the position in space of one of the parties? Does the standing person tend to ask questions of the person positioned at a "lower level" regardless of the agenda topic? The person in the "lower level" position has a smaller range of body movement (a communication mode) available to to him — how does this make him feel in relation to the standing person? Does the standing person feel more comfortable standing while on the Illness agenda than on the Social agenda? What of the urge to sit, or not sit, in that convenient chair? If you feel more comfortable sitting or standing, how does it affect the participation of both parties in the interaction?

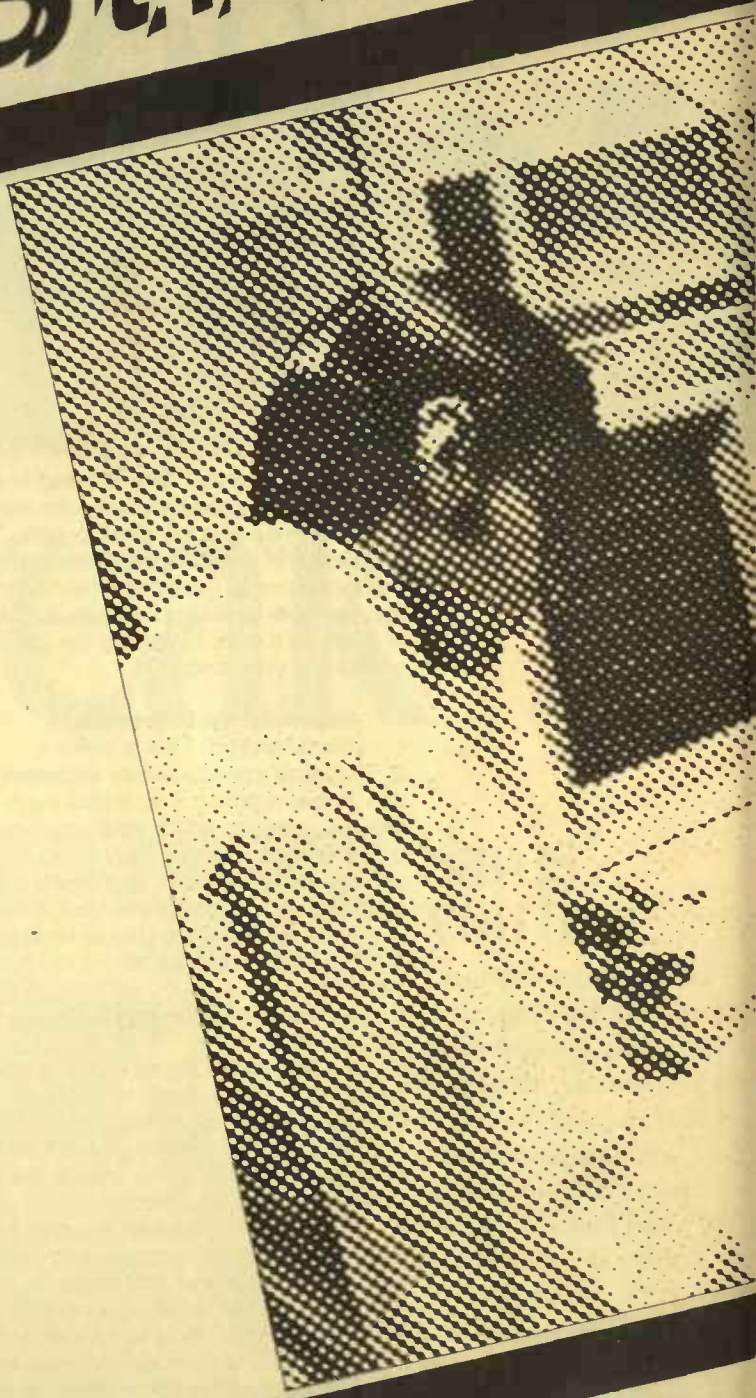
The questions to be considered are as endless as your own curiosity and concern about the nature of nurse-patient interaction.

These days we are all concerned about truly "communicating" with patients. We sometimes have the mistaken notion that this is happening when *we listen and they talk* or *when we talk and they listen.*

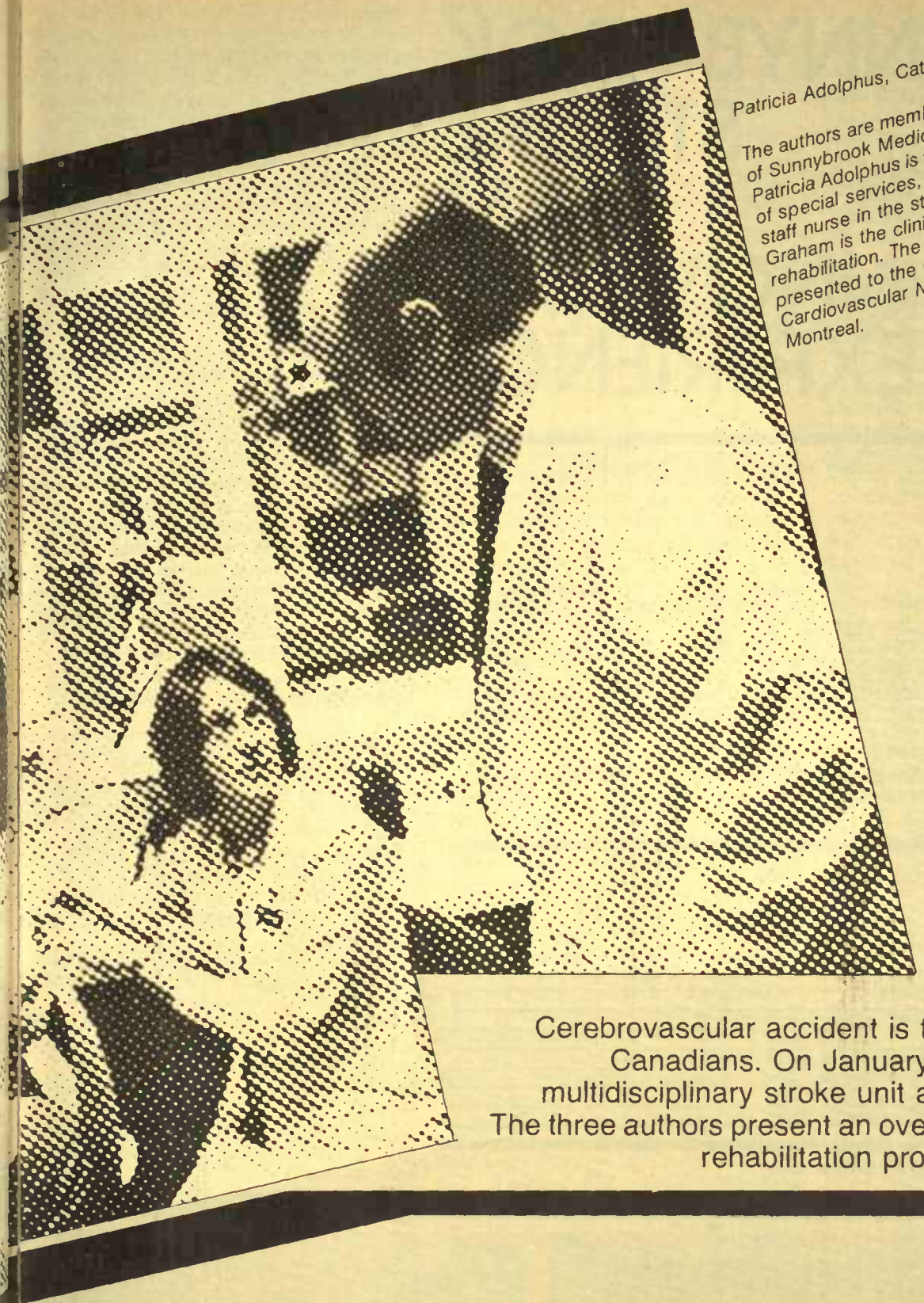
Here is an unproven hypothesis and further unanswered questions: The person who stands above the other will assume dominance in amount and content of communication. Would we allow this dominance to the patient by sitting below his/her eye level? Would we gain more data this way? Would this affect our helping role favorably or unfavorably?

Time is precious. Time studies have shown that patients experience a 3-minute "sitting" helper being there for longer than 3 minutes, and a 3-minute "standing" helper being there for less than the actual 3-minute period. We spend endless hours complaining that we do not have "time to spend talking to patients." Yet we do spend at least 3 minutes with a patient every day. Are they the best possible 3 minutes for the patient?

Stroke



Photos by Sunnybrook Medical Centre



Patricia Adolphus, Catherine Pallant, Linda Graham

The authors are members of the nursing staff of Sunnybrook Medical Centre, Toronto. Patricia Adolphus is the nursing administrator of special services, Catherine Pallant is a staff nurse in the stroke unit, and Linda Graham is the clinical nurse specialist in rehabilitation. The material in this article was presented to the Canadian Council of Cardiovascular Nurses, last October, in Montreal.

Cerebrovascular accident is the third largest killer of Canadians. On January 6, 1975 Canada's first multidisciplinary stroke unit admitted its first patient. The three authors present an overview of the unit and the rehabilitation process of stroke patients.

Stroke

SUNNYBROOK STROKE TEAM —AN INNOVATIVE EXPERIENCE

In the first year of operation 134 patients were admitted to the Stroke Unit. The following statistics were gathered:

		Stroke			Non-Stroke
Total Number:		101			33
	Males (mean age)	59	(66*)		
	Females (mean age)	42	(75*)		
Diagnosis:	*Cerebral Infarction*	91		*Epilepsy*	14
	Other (SAH, SDH, etc.)	10		*Other*	21
Average Duration of Stay:		8.6 days			2.6 days

Only 8 deaths occurred during the year: 7 strokes; 1 diabetic coma.
The "Report of the Joint Committee for Stroke Facilities" notes that, in general, 50 percent of stroke victims die within the first month.

Further statistics, gathered on 39 stroke patients, follow:

		Patients with cardiac disease	Patients without cardiac disease
Total Number:		30	9
Incidence of Arrhythmia:		13	2
Type of Arrhythmia:	*Premature ventricular beat*	7	2
	atrial fibrillation	4	
	Paroxysmal atrial tachycardia	2	
	premature atrial beat	1	
	nodal rhythm	1	
	ideo ventricular rhythm	1	

* *The range of ages was: for males 48-87 for females 49-82*

There are many definitions of a "stroke" or CVA, but for the purpose of this article it is: *a rupture or blockage of a blood vessel in the brain, depriving parts of the brain of blood supply, resulting in loss of consciousness, paralysis or other symptoms depending on the site and extent of brain damage.*

The main cause of CVAs is a hardening of the arteries to the brain which in turn is related to high blood pressure, diabetes, and other factors producing a progressive hardening of the arteries. In Canada, cerebrovascular accident is the third largest killer after heart disease and cancer, and is probably the most common cause of long-term disability.

Stroke patients in most hospitals are cared for on medical wards and have often been regarded with despair and frustration. At Sunnybrook Medical Centre, we have been treating stroke patients on the neurological ward, and to further improve on diagnosis, treatment, and rehabilitation of these patients, we have opened an acute stroke unit. The patients stay in the unit for 4—5 days and are then transferred to the neurological ward for the remaining time in hospital. We have established a team approach in treating these patients, combining the skills of neurologists, cardiologists, neurosurgeons, neuropsychologists, physiatrists,* nurses, physiotherapists, occupational therapists, speech therapists, and social workers.

History of the Unit

A few years ago, a man named Graham MacLachlin suffered a stroke. He was admitted to Sunnybrook Medical Centre where he made steady progress. Upon discharge, he was unable to assume his previous position in the business world and, being a man with an active and inquisitive mind, he became interested in the cause and effect of strokes.

To gain knowledge in this area, he spent many hours in medical libraries reading books related to strokes. MacLachlin initiated a stroke fund and within two years it amounted to more than $100,000. Once approval was obtained from the executive director and board of trustees, a stroke committee was formed.

Many hours of discussion, planning and looking at equipment ensued. Final results were as follows:

* *Physician who specializes in rehabilitation medicine.*

Two four-bed wards were remodeled into five-bed intensive care unit.(See figure 1)

A central area was partitioned with glass provide a working area, i.e. central monitor, edications, telephone, etc. (See figure 2).

Panels were installed featuring: oxygen, acuum, compressed air, time-lapse clock, mergency buzzer directly to "locating" for rdiac arrests, emergency buzzer to the ain nursing station, sphygmomanometer, nd control of overhead examining lights with timing device.

Adjustable I.V. poles were mounted in e ceiling.

A cardiac monitor was installed at each edside, capable of monitoring ECGs and BP multaneously. (One has an extra feature — onitoring intracranial pressure). The ecision was made to install cardiac monitors ecause of the close relationship between eart disease and strokes:

- if the heart is failing as pump, there is a hance that not enough blood will reach the rain.
- a damaged heart is more likely to throw mboli that could occlude an artery leading to e brain.
- if atherosclerosis (the most common cause coronary disease) is detected elsewhere in e body, then there exists a high possibility at it is also present in the arteries leading to e brain.

By monitoring these patients, we hope to stablish a relationship between cardiac regularities and brain function. Since the pening of the unit, we have observed cardiac regularities in 70 percent of stroke patients.

Stretcher beds were chosen to facilitate obility to and from X-ray for arteriograms, rain scans, EEGs, etc.

An air conditioning unit was installed and n oil painting donated by the founder.

Because of the size of the unit, it was not easible to staff it separately. Therefore, it is nder the jurisdiction of the head nurse on the eurology ward, and all staff nurses from the ard rotate through as they develop nowledge and expertise in caring for these atients.

One of the main problems we faced was ow to prepare nurses for a unit with which no ne had any previous experience. We ecided to approach the problem by using ore aids to assist in our nursing care and bservations, and by realizing that the patients would be similar to those we had been nursing on the neurological ward. Our preparatory program included:

— a series of lectures and discussions regarding neurological conditions, including strokes, under the direction of our neuroscience nurse clinician, a neurologist and a neurosurgeon

— a course in basic arrhythmias, the completion of which was a prerequisite to working in the unit

— discussions with the staff regarding progress and what to expect once the unit was in operation

— instruction in chest physiotherapy

— an intensive orientation of staff as soon as the unit was ready

— a demonstration of the use of the panels, monitors, and stretcher beds.

Canada's first multidisciplinary stroke unit admitted its first patient on January 6, 1975 (on nights) and all systems were go. As could be expected, there was a lot of discussion regarding the criteria for admitting patients to the unit, such as age limits, infarction only, hemorrhages only, etc.

Criteria for admission to the unit:

- First complete stroke
- Stroke in evolution
- Transient ischemic attacks

The largest group of misdiagnosed admissions has been people in the postictal state of a seizure.

Goals of the Unit:

1 To enhance the diagnosis, treatment, and rehabilitation of stroke patients by:

— providing a suitable environment with modern equipment to facilitate the intensive observation and care of these patients

— providing nursing staff who have advanced preparation in intensive care nursing of neurological patients

— providing a multidisciplinary team with special interest in cerebrovascular disease.

2 To undertake an ongoing evaluation of new diagnostic and treatment methods.

3 To establish a model unit to increase the awareness of the factors involved in stroke management.

4 To evaluate the effectiveness of such a unit in the progress and ultimate recovery of the patient.

In addition, we hope to create a climate of understanding, patience, and encouragement within which the patient is supported emotionally and motivated to function. We hope to help him and his family understand the problems related to his stroke and help them learn to cope.

Medical Coverage

Two neurologists take turns as director of the unit on a two-month rotation. One neurologist does all the protocols daily and one is responsible for the care of the patients. Once discharged from the unit to the ward, the patient is turned over to his appropriate doctor.

Current situation

At the present time, almost exactly a year after the unit opened, sleep EEGs are being done on many patients to identify the relationship between the disturbance shown and the part of the brain damaged. A pattern is emerging — patients who show normal sleep patterns on admission are likely to do well; those who do not show normal sleep patterns either die or will need chronic care. Also,

— Classes in arrhythmias are being continued.

— Instruction in chest physiotherapy is being continued.

— Multidisciplinary conferences take place three times per week with neurologists, nurses, neuropsychologists, physiotherapists, occupational therapists, and speech therapists. The patients are discussed and plans for their care are made.

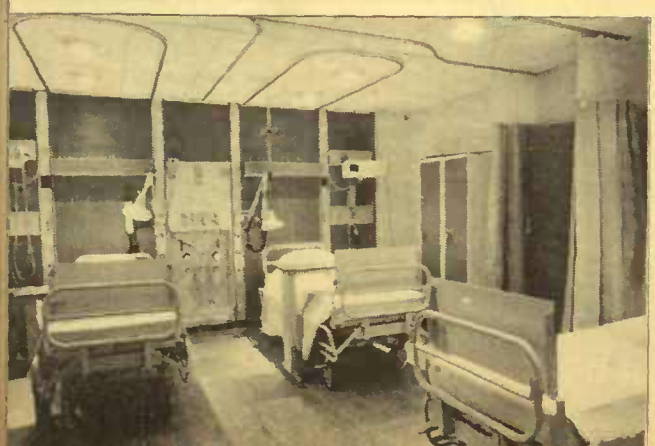
— A weekly conference is held with cardiologists, neurologists, and nurses to discuss the cardiac status of the patients.

— All patients are referred to the neuropsychologist for testing of intellectual impairment.

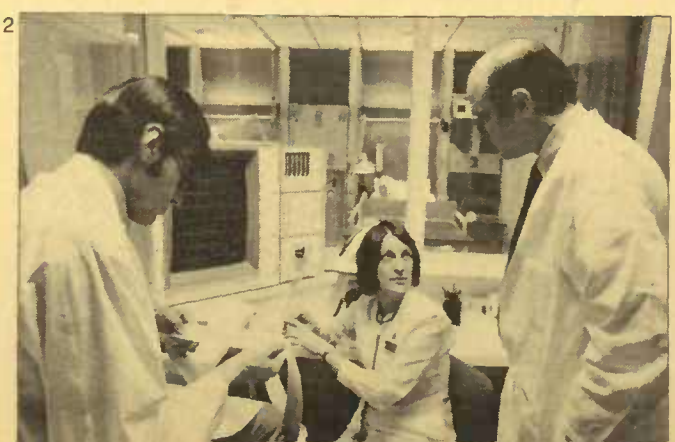
— The standardization of the medical assessment of strokes is being developed.

— Cerebral blood flow studies using Xenon are being carried out.

Patricia Adolphus (R.N., Sherbrooke Hospital, Sherbrooke, Quebec; Certificate in Nursing Administration, University of Toronto) is the nursing administrator of special services at Sunnybrook Medical Centre, Toronto.



2



Stroke

ACUTE NURSING CARE IN THE STROKE UNIT

Until recently "the attitudes of many health care professionals toward stroke patients have been those of despair, hopelessness, disinterest, and avoidance."[1] At Sunnybrook we discourage these attitudes and promote an innovative multidisciplinary team approach to the care of stroke patients.

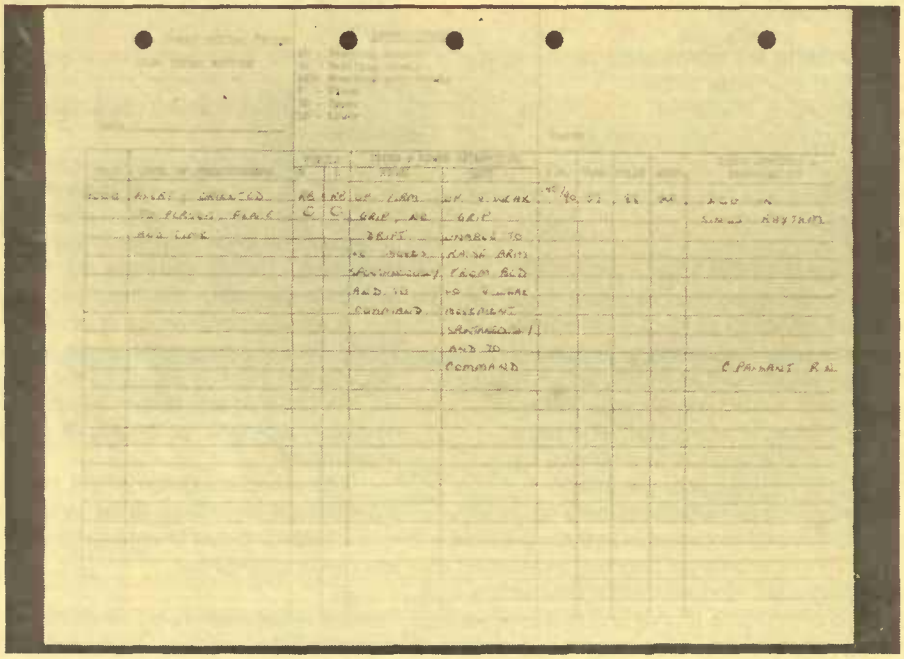
As a member of this team, the nurse in the Stroke Unit provides an acutely ill person with consistent nursing care, preventive rehabilitative measures, and psychological support. She also plays an important role in the research and education involving the unit. With comprehensive knowledge of strokes, their etiology, types, and effects, she is better able to understand the stroke patient and meet his special needs.

The effects of a stroke depend on the site and extent of brain damage. A stroke in the left hemisphere (see figure 3) results in impaired motor ability on the right side. Sensation and proprioception are decreased on the right and tactile discrimination is poor. The left hemisphere is 88 percent dominant in the speech center for both left- and right-handed people; therefore, a left hemispheric stroke results in speech difficulties such as receptive or expressive aphasia or dysarthria. These patients may have difficulty with concepts and abstractions and may have a poor short-term memory. The patient could lose the ability to judge solutions to verbal problems and retain the ability to hear and follow visual commands, but to a lesser degree. The patient may have difficulty understanding the words he reads and be confused by a variety of stimuli. Those who suffer a left hemispheric stroke tend to be slow, methodical, and anxious.

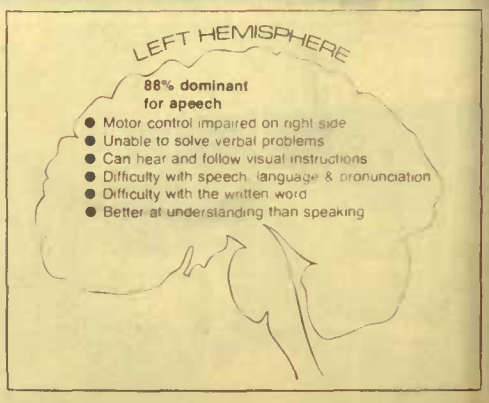
A stroke in the right hemisphere (see figure 4) results in impaired motor ability and sensation on the left side. The patient's balance may be poor and he may have perceptual difficulties, such as difficulty judging positions, distances, rate of movement, form, and the relation of his body or its parts to the objects around him. Impaired spatial learning or motor memory is possible and he may neglect his affected side, may have difficulty with right and left discrimination, or have poor tactile discrimination. Those who suffer a right hemispheric stroke tend to lack prudence, are easily distracted, have a poor memory, and are emotionally labile.

A stroke in the brainstem basically results in cranial nerve abnormalities and the patient

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omplains of such things as vertigo, diplopia, impairment of vision.

Admission procedure

Most patients are admitted to the unit rectly from Emergency but some are referred y other hospitals. The nurse completes an dmission note with the help of the family, cluding information about the patient's past edical history, allergies, medication, diet, imination habits, hygenic preferences and cial background. With this information the urse develops a care plan that is revised as e patient progresses. The family is oriented the unit and encouraged to visit, one at a me, for short periods between 1100 and 100 hours. Neurological rounds are made ree times weekly and all members of the am are invited to participate. Everyone is us familiar with the patient's progress and ssists the nurse in keeping her care plan p-to-date.

Immediately upon admission to the troke Unit a *head injury routine* that includes n evaluation of the patient's level of onsciousness, pupillary reaction, motor ower, and vital signs is done by the nurse. see figure 5) Patients admitted to the Stroke nit are on head injury routine every one or vo hours for the first twenty-four hours and hen every four hours. The physical layout of he unit permits the patient's neurological tatus to be monitored and any change is mmediately reported. Even a slight alteration n a patient's level of consciousness or pupil ize may be indicative of pathology requiring rompt attention.

As soon as the patient is admitted to the nit, cardiac monitoring is initiated and ontinues until discharge from the unit. lon-stroke patients in the unit are monitored s a control group for research purposes only.

Besides providing research data, the ardiac monitor and the nurses' ability to ecognize abnormalities have resulted in the arly detection and prevention of cardiac rrhythmias. According to the doctors, seventy ercent of stroke patients studied have had ome form of cardiac disease or have isplayed arrhythmias. Twelve lead ECGs and ardiac enzymes e.g. LDH, SGOT and CPK re obtained the first three days after a atient's stroke to rule out myocardial nfarction. The cardiologist does rounds veekly with the neurologists to familiarize himself with the patients and their cardiac status.

The nurse's role in research also involves the sleep EEGs. The EEG runs continuously from 2300 —0600 hours and it is the nurse's responsibility to begin, discontinue, and monitor the recording. These EEGs are studies of the sleep patterns of stroke patients. The doctors would like to discover whether or not the disturbed sleep patterns, of which there have been many, are environmental or pathological. A strong relationship appears between degrees of unconsciousness and the sleep pattern, and there may also be a relation between the site of pathology and the sleep pattern.

The patient's fluid balance is monitored by accurately recording intake and output on each shift. Intravenous solutions are administered to those patients whose oral intake is below 1500 ml per day. If a patient is unable to drink due to motor impairment or unconsciousness, tube feedings are given. The feedings have one calorie per ml, and the patient is started on quarter strength and builds up to full strength feeding. Patients are given 200 — 400 ml five times a day depending on their needs. While administering a nasogastric feeding it is important to keep the patient's head elevated to prevent aspiration. The patient is encouraged to take sips of fluid even with the tube in place so that it may be removed as soon as possible.

Acute stroke patients need individual consideration with regard to bladder function. Our patients are not automatically catheterized and the need for an indwelling catheter is assessed by the nurse and the physician. A bladder is often flaccid for the first 48 hours after a stroke and then becomes spastic. The return of tone in the bladder appears to coincide with the return of tone in the affected arm. Our rehabilitation consultant, believes that the best method for bladder training is intermittent catheterization (catheterized q4 hours to residual below 100 ml then q6 hours and then q8 hours). The second choice is a catheter clamping routine (clamp for 2 hours then off for 20 minutes, gradually increasing time). This retraining begins in the unit because an indwelling catheter increases spasticity and decreases the capacity of the bladder. Incontinence can be the result of mental rather than motor dysfunction and bladder tone must be preserved to spare the patient additional difficulties in rehabilitation.

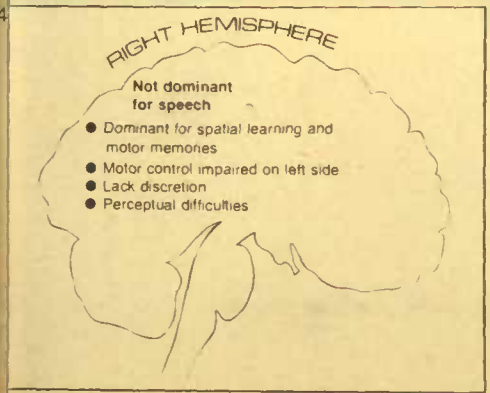
Preventive Nursing Care

The nurses in the Stroke Unit realize the importance of preventive rehabilitation. We strive to avoid the effects of prolonged immobility such as pneumonia, contractures, and discomfort in the affected limbs. We work to maintain skin integrity and to promote range of motion in the joints.

Pneumonia is always a threat to the elderly and bedridden patient. We turn and position our patients at least every two hours so that both lungs expand as much as possible. The physiotherapist is active in the patient's care from the first day — clapping, vibrating, and suctioning congested chests. The nurses provide this therapy during the evening and night shifts and on the weekends when the therapist is not available. If the patient is able to cooperate, he is encouraged to deep breathe and cough five times in one hour. Sputum specimens are sent for culture, and sensitivity and antibiotic therapy is initiated if necessary.

Maintaining skin integrity is an important part of the nursing care of an acute stroke patient. Because many of these people are unable to turn themselves they risk decubitus ulcers. The patient is turned and positioned every two hours and pressure points are inspected and rubbed. When the patient is turned he is lifted and not pulled across the sheets. We attempt to keep pressure off all boney prominences, e.g. by elevating the heels with a small pillow, using Posey booties, and elbow pads. Turning sheets are also very helpful in preventing skin breakdown. An air mattress that changes pressure points is used for patients whose skin is difficult to protect. Keeping the patient and the linen dry is essential to prevent skin breakdown. If the patient has developed a decubitus ulcer or is admitted with one, we have found that the following steps are effective in promoting healing — the patient is kept off the area, the ulcer is exposed to the air, and it is kept dry. The steps are easy and basic but surprisingly successful.

The development of contractures or pain in the patient's affected limb can badly hamper his rehabilitation. While the patient is in bed he is placed in a variety of positions and the length



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of time on the affected side is limited. Correct body alignment is maintained using devices such as pillows, footboards, and sandbags.

When being turned the patient is lifted with firm support under the joints; subluxation or incomplete dislocation of the shoulder could result from pulling on a patient's arm to move him. The patient is encouraged to assist in turning, but only to the extent of his ability.

While positioned supine, the feet are placed against the footboard at right angles to the legs — this prevents footdrop. Knee flexion is avoided because "knee flexion contractures of more than twenty degrees leads to inability to learn to walk; transfer from bed to chair; or chair to toilet."[2] While the patient is supine we try to prevent a frozen or tight shoulder by supporting the patient's affected arm on a large pillow that is tucked well up in the axilla. When positioned on his side the patient's head and trunk are in alignment and the arm is supported away from the body at shoulder level, elbow slightly flexed, with the hand in line with the forearm. To prevent dislocation, the affected hip is not allowed to drop forward and the leg is supported with pillows to prevent pressure. Because an armboard prevents early mobility of the arm, intravenous solutions are not infused into the affected arm. The care of the intravenous could also result in damaging manipulation of the limb.

Passive range of movement is "the extent of movement within a given joint achieved by an outside force, without the assistance or resistance of the patient."[3] This is a vital therapeutic routine for it can prevent permanent or long-term disability. The physiotherapist visits the patients in the unit daily and the nurses incorporate range-of-motion exercises into the patient's daily care. Each movement is done slowly in smooth motions about five times, the patient is never pushed beyond his existing range of motion and force is never used. By watching the patient's facial expressions, the movements are kept pain-free.

Our patients are encouraged and instructed to do some of their own exercises as soon as they are able. Even in an acute care unit many patients can become involved in their rehabilitation. One of the easiest exercises is shoulder flexion — the patient holds his affected arm, grasping it at the elbow and then lifts his arms to shoulder height and down again, repeating two or three times.

Patients in the Stroke Unit are mobilized out of bed on the fourth day, if their neurological and cardiac status is stable. This early movement is helpful in preventing the effects of immobility and gives the patient a psychological lift. The family of the patient is always pleasantly surprised to hear that their relative has been up. They are encouraged to provide the patient with his own housecoat, slippers and toiletries. Having his own belongings often improves the patient's self-image and stimulates a healthy interest in his own appearance.

Psychological Support

The nurse in the Stroke Unit not only provides acute nursing care and preventive rehabilitative measures; she must also cope with the patient's psychological response to his stroke. A previously active person who is suddenly paralyzed and unable to speak, reacts with fear, anger, depression, frustration and emotional lability.

The nurse realizes that the patient is afraid he will be incapacitated for the rest of his life and will never be able to return home. She assists her patient to work through his feelings of depression and frustration. She is aware that improvement will be inconsistent and never chastises the patient for being unable to perform. By stressing the day-to-day improvement she encourages the patient to take one step at a time. She does not allow him to attempt too much, understanding that as the patient becomes fatigued he is less capable and more easily discouraged. She reassures her patient that these feelings are normal and helps him to redirect this energy toward rehabilitation.

If the patient is emotionally labile the nurse explains to him that she understands he cannot always control his feelings. It is also her responsibility to help the family understand and cope with their relative's emotional response. It is not uncommon for a patient to cry at the sight of his family but this certainly does not always indicate unhappiness.

As a result of the stroke, the patient's body image may be disturbed. He may perceive himself differently because of visual disturbances, or his appearance may be distorted as the result of a facial droop or flaccid limb. The nurse endeavors to improve the patient's feelings about himself by maintaining his individuality, e.g. a female appreciates the application of cosmetics, a male enjoys a daily shave and most patients feel more like themselves in their own sleepwear. The individual is always addressed by his proper name and is not given a nickname.

The nurse must be empathetic but not sympathetic. She must encourage and reinforce any improvement, stressing the positive and accepting the negative. She must understand what each patient's disability means to him and to his future. Most important, the nurse must come to terms with her own feelings about stroke.

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APHASIA A NURSE'S GUIDE TO COMMUNICATING WITH APHASICS

- *1. Help the aphasic maintain a desire for communication by encouraging all his attempts at communication.*
- *2. If the aphasic makes errors in his speech, it might be good to correct him. But if you are not familiar with his own means of facilitation, then say the word or the sentence he wants to express and encourage him to try a second time.*
- *3. Avoid raising the intensity of your voice when speaking to an aphasic.*
- *4. Give instructions clearly but naturally. Use simple sentences and if necessary put emphasis on the most important words. Remember that the aphasic's comprehension of language is better if you speak about an event, an object or a person present in the situation.*
- *5. If you cannot understand what the patient is trying to say and if he nevertheless persists unsuccessfully in his attempts, then it is better to change the subject of the conversation and tell the patient: "We will leave it at that for the moment and come back to it later on."*
- *6. If the patient is totally unable to express himself, then formulate your questions so as to have "yes" and "no" answers. But you have to know your patient very well to be sure that the signs he uses really refer to "yes" and "no".*
- *7. While performing your clinical activities, you can contribute to the language stimulation by verbalizing what you are doing. But avoid unnecessary verbiage with the aphasic; you must insist that he keep silent while you are conducting your treatment.*
- *8. Encourage the patient to use social expressions like "hello", "how are you," "I'm fine," "how's the weather," etc.*
- *9. If the patient is severely dysarthric or apraxic without a concomittant aphasia, you can encourage him to write what he wants to say. If he has a paralysis that prevents him from writing, have him point to letters of the alphabet.*
- *10. Do not be surprised if the patient swears when he is unable to utter a word. Give him, if possible, the word he is looking for.*
- *11. Give the aphasic all the time he ne ds to express himself. Do not interrupt him by offering him all kinds of words or sentences that can only contribute to increasing his confusion. If his attempts are unsuccessful, give him the missing word or the beginning of the word so that he can finish it by himself.*
- *12. Do not hesitate to make jokes with the aphasic. He can sometimes enjoy them as well as any other person.*
- *13. Avoid carrying on a conversation in the midst of background noise. Turn off the television set and ask the others present not to interfere.*
- *14. If you have aphasics regularly in your department, a scrap book with illustrations of daily activities in a hospital is recommended. By pointing to them, the aphasic will be able to make his needs known.*
- *15. Avoid changing the routine activities without preparing the patient. For example, if the patient has to change rooms, prepare him in advance and give him explanations.*
- *16. Ask the family to bring photographs of the aphasic's children and his favorite magazines. Have information about his work, his habits, and his hobbies to start a conversation on a familiar subject. They can also be used to understand what the aphasic is trying to communicate.*

This guide was prepared by Louise Coderre, speech pathologist, The Rehabilitation Institute, Montreal, Québec.

Stroke

STROKE REHABILITATION —A CREATIVE PROCESS

What do Robert Louis Stevenson, G. Frederick Handel, and Louis Pasteur have in common? They all suffered strokes! More important, they all recovered sufficiently to continue their life's work. Handel wrote the Messiah and Louis Pasteur accomplished 90 percent of his research after having a stroke. The lives of these men offer unquestionable evidence that a cerebrovascular accident need not result in total disability.

> *Rehabilitation is a creative process that begins with immediate preventive care in the first stage of an accident or illness. It is continued through the restorative phase of care and involves adaption of the whole being to a new life.*[4]

Rehabilitation is also a teaching-learning process in which the patient is actively involved. At Sunnybrook, because the patient is cared for by a multidisciplinary team, his rehabilitation is not only physical, but also mental, social, economic, and vocational. The team members use the same fundamental approach for each patient and therefore are able to supplement and complement each other. The major portion of rehabilitation is carried out on the neurological ward and the central focus of the stroke team is the patient.

The team must care for not merely a body with impaired functions, but rather a human being whose disability is an integral part of his total person. As part of the team, the nurse must be capable of exercising initiative and judgment in making nursing diagnoses, in planning and implementing the patient's care, and in evaluating and modifying the plan of care as the needs of the patient change.

The three basic aims of the team, and particularly of the nursing members, are:
— prevention of further impairment
— maintenance of existing abilities
— restoration of as much function as possible.

Prevention of Further Impairment

To prevent further impairment, a nurse must be future-minded. "Far too many patients have a prolonged or postponed rehabilitation program because of the need to correct or minimize a problem that should never have been allowed to occur."[5] Correct positioning is a basic nursing measure and important

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* *Velcro is a Registered Trademark of Velcro Corp.*
* *Dulcolax is a Registered Trademark of Boehringer Ingelheim*

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whether the patient is sitting in a wheelchair or standing. While sitting, the patient must keep his body aligned. This is difficult for most stroke patients due to the hemiplegia and visual disturbances. Subluxation or partial dislocation of the shoulder and edema of the hand could occur because of the hemiplegia. Some of the preventive aids that we use at Sunnybrook are:

- a trough with Velcro* straps for the arm of the wheelchair to keep the patient's affected arm in a comfortable position (See figure 6)
- a pillow across his knees to support the affected arm
- occasionally, a sling. (See figure 7)

A portable full-length mirror allows the patient to see how he is sitting and this helps him to maintain a total body image. A patient, positioned comfortably in the wheelchair, needs to shift his weight every few minutes to prevent skin breakdown, and the patient and staff should check frequently for any signs of friction, cuts or bumps resulting from transfers to the wheelchair, or the use of the wheelchair.

A patient's rehabilitation progresses more safely when the nurse and the patient follow these few precautions.

For patients who are able to walk, correct posture is less tiring than incorrect. When a cane is required, it is held in the unaffected hand (See figure 8). If the paralyzed arm is flaccid, the patient wears a sling to prevent the arm from getting in the way, being injured if sensation is diminished, and dragging the shoulder down. If a sling is worn, it must be taken off periodically and the arm exercised.

Proper body positioning is an important part of the patient's rehabilitation program. Bladder retraining is important because incontinence is unacceptable in our society.

Regardless of the bladder program followed, adequate fluid intake is a must, and frequently the patient is unable to see the glass of juice in front of him, reach and grasp it easily, or ask for something he likes to drink. As a result, he easily becomes dehydrated which creates several problems, e.g., dry skin, burning on urination. The most obvious way to check his intake is by output. If he is voiding small amounts of concentrated or foul-smelling urine, his fluid intake is increased. Fruit juices, water and soups are encouraged. More than a couple of glasses of milk a day are discouraged as the calcium may create further kidney and bladder difficulties in the inactive patient. Most stroke patients try to drink 3,000 ml of fluid spread throughout a 24-hour day.

A daily bowel program is extremely important for stroke patients as they tend to become constipated easily. The patient's routine prior to the stroke is followed as closely as possible and the nurse encourages fluids and roughage in the diet. His bowel movements are charted daily and if he is used to having a daily bowel movement and doesn't, he receives a laxative.

The use of a commode is helpful since it is a more comfortable and natural position and allows more privacy. If a patient is confused and the date of the last bowel movement is not known, a rectal examination is done. With most patients, a Dulcolax* suppository works more effectively and less traumatically than an enema.

The prevention of further impairment requires a total team approach. The nurse uses many of her basic nursing measures to meet the individual patient's needs. The nursing care plan indicates these needs and allows for modification after evaluation.

Maintenance of Existing Abilities

Maintaining the patient's existing abilities is accomplished by getting him out of bed and encouraging activity. Every day of immobility requires three days of activity to regain the strength and endurance lost.[6]

Restorative Phase

Restoring function is a goal most patients and all team members eagerly pursue. A couple of the basic rules are:

- assist the patient when necessary, but do not "do" for him
- progress slowly, gradually increasing the patient's abilities and tolerance

The main aspects of the restorative phase are speech, activities of daily living, and the family.

I Speech

It is during the restorative phase of rehabilitation that the patient must become actively involved in the teaching-learning process. For the patient to effectively learn, the teaching process must be adapted to meet the needs of each particular person. For the patient who has suffered a stroke in the left hemisphere, the following guidelines apply:

— don't overestimate the patient's ability to comprehend speech; use simple word commands
— use simple demonstrations
— break any task into small steps
— give frequent encouragement

For the patient with a right hemispheric stroke:

— use verbal cues, few visual distractions and slow movement around the patient
— keep the room well-lighted
— break a new learning task into small segments that the patient completes one step at a time.
— watch to see that the task is safely completed because the patient frequently overestimates his abilities.

The speech of a patient who has had a stroke can be affected in several ways. The main difficulty is aphasia, which means that the patient has a disturbance in understanding others and in expressing himself.

Aphasia is classified very generally as receptive, expressive and global. *Receptive aphasia* is the inability to comprehend spoken and/or written symbols. *Expressive aphasia* is the inability to express ideas in speech and/or writing. *Global aphasia* is a combination of a complete receptive and expressive deficit.

This deficit means that not only is a patient's speech affected, but also his understanding of speech, reading, writing, and arithmetic. A patient can seldom be classified as having expressive or receptive aphasia; more often than not, a mixture of the two problems appears, although one deficit may be greater than the other.

Some key findings from recent interviews with post-stroke patients[7] regarding their aphasia, follow:

- The capacity to understand returned very shortly after the stroke and it consistently increased long before the patient was able to respond to what he heard.
- Staff need to speak more slowly and to present one question at a time.
- People need to be aware of their subtle signs of impatience while waiting for the patient to speak, e.g. audible sighs and eye movements. This behavior affects the patient's morale, motivation, and progress adversely.



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Stroke

The aphasic patient usually has complicated problems to solve. He is evaluated by the speech pathologist who works with him on an individual basis; during the rest of the day, team members follow through with a similar approach. (see box)

The speech board (See figure 9) is a device used to assist the patient. He points to the item desired, the nurse names the article and the patient repeats it. The patient can also be asked to describe the article or point to a specific item. If a patient is having trouble finding a word, it is not supplied for him immediately. However, if he has attempted the word a couple of times and is unsuccessful, the word is spoken — he is then able to repeat it.

The patient's speech tends to be inconsistent from day to day. The ability to say a word or a phrase one day does not mean that he can do it the following day; comments like, "but you said it yesterday" only increase the patient's frustration. His speech is usually best early in the day, before he becomes physically tired and emotionally frustrated.

The patient's family needs a lot of support and explanation. Some examples of problems we have encountered are:

- Following his stroke, a patient spoke his native language of Finnish rather than his second language of English. The family were told that bilingual patients usually find it easier to use their native language rather than the acquired language.
- A deaf and mute woman had to relearn her hand signs.
- A patient, who had seldom sworn before his stroke, was using strong profanity frequently following his stroke. The family and staff had to learn to accept this language without comment or displeasure as the patient was using automatic speech and was unable to stop the responses.

The key things to remember are that aphasia affects each person differently, and that it can involve a disturbance in understanding others as well as expressing oneself.

II Activities of Daily Living

Activities of daily living,ADL, include the patient's ability to transfer to the wheelchair and toilet seat, bathe, dress, and feed himself.

With ADL, the physiotherapist, the occupational therapist, and the nurse work closely together in order to coordinate and reinforce each other's teaching.

Most stroke patients use a wheelchair until they learn how to walk again.

A one-wheel-drive wheelchair is available for the patient, but is not necessary since most hemiplegic patients can propel and steer a regular wheelchair with one foot and hand.

However, an extension of the brake handle on the paralyzed side may be necessary. To facilitate transferring, the wheelchair is always placed on the patient's unaffected side. This allows the patient to see the wheelchair and lead with the stronger side; thus he has less chance of "tripping" over the weaker leg, and can protect the affected side. (See figures 10 — 13)

A knee lock is used on the stronger leg in order to prevent the knee from buckling or the foot from slipping during the transfer. The patient gradually progresses from being assisted by two people to eventually being unassisted.

When transferring, he is encouraged to place most of his weight on his stronger leg, to stand tall, and to look where he is going. Once in the wheelchair, the patient is taught how to position himself correctly.

Bathing and dressing with only one arm can be extremely difficult and frustrating.There are regular bathtubs available with safety bars for those patients who are able to use them.

However, many of the patients wash themselves at the bathroom sink. With practice, most of the patients are able to brush their own teeth and dentures. The female patient's hair is usually curled by the staff, although there is a hairdresser located within the hospital. An electric shaver is available for the male patient's use. Frequently, a patient may neglect to shave one side of his face and a gentle reminder is necessary.

To feed himself, a stroke patient may need to use a few aids to replace the functions of his paralyzed arm. A rocker knife (See figure 14) with a serrated edge allows the patient to rock the knife back and forth to cut his food and the prongs on the end of the knife can be used as a fork. A plate guard (See figure 15) prevents the food from being pushed off the plate and a non-slip mat can be placed under the plate to hold it firmly.

A bread-buttering board (See figure 16) with suction cups holds a piece of bread steady while the patient butters and cuts it. Each patient is assessed by the occupational therapist and the necessary devices are provided for assisting in the patient's activities of daily living. If the patient is able to function independently, his self-esteem is greatly improved.

Relearning how to dress and undress himself is always a struggle for the patient. However, once he has mastered even a small part of dressing himself, he begins to regain his dignity and self-respect. As soon as the patient leaves the Stroke Unit, he begins to learn how to dress independently. The nurse and occupational therapist work together, reinforcing each other's teaching.

The stroke patient finds it easiest to get dressed in the wheelchair since he is sitting upright. To put on a shirt, blouse or sweater, the patient is taught to begin by pulling his weaker arm through the sleeve with his stronger arm. He pulls the shirt as far up his arm as possible, brings the other sleeve around behind him and puts his stronger arm through the correct sleeve. He then pulls the shirt down and does up the buttons, beginning at the top of the shirt. If the buttons are too small, he may need to use a button hook, (See figure 17) replace them with larger ones, or use Velcro tape. It is important to remember that the patient does not have the use of one arm, and therefore loses the ability to stabilize whatever he is doing. As a result, any device that is used must have a stabilizing effect.

Underwear and pants are also easier to put on while sitting in the wheelchair. The affected leg is put in the pant leg first and then the unaffected leg. The pants are pulled up the legs as far as possible and then the patient can either stand and pull the pants all the way up or continue to sit and, with a side to side motion, pull the pants up a little at a time. Once he has his shirt and pants on, the patient checks that his shirt front and pants are straight, that his shirt collar is arranged properly, and that he is not sitting on any wrinkles.

The patient may need to use a sock-aid to pull on his socks. Elastic shoelaces are available that remain tied and allow the patient to put his shoes on like a loafer. He may need to use a long-handled shoehorn if he has difficulty with his balance when leaning

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over. Zippered shoe laces (See figure 18) can be tied into the shoe, allowing the patient to remove his shoes by pulling the zipper down.

A few essential "extras" are necessary to help the patient feel like a human being. Some patients have difficulty judging the passage of time, so they need to wear their watches. Obviously, the desired effect is lost if the nurse merely puts the watch on the patient's wrist without winding and setting it. Perfume, cosmetics, and jewellery for the women, and aftershave for the men, are important if they were used before the stroke. Glasses, properly positioned and *cleaned,* are a must. The vision of many of the patients is already blurred, so why increase this difficulty with sticky, smeared glasses?

Throughout their lives, all patients have established routines for their activities of daily living. Following a stroke, these elderly people must relearn or change their ways in order to adapt to a new lifestyle. Most of them can learn to cope effectively. How untrue the cliché — "older people are set in their ways!" As stated earlier, rehabilitation is also vocational and economic. Vocational assessments are done by the occupational therapist on most patients. A kitchen assessment is done with all housewives and suggestions are made to help the patient work out any problems she may be having.

III The Family

Stroke patients are in need of personal support, especially during later stages of recovery: it is at this time that they are most often ignored. There are several ways to offer support to the patient. When referring to the patient's body, the stronger and weaker sides are mentioned rather than the "good" and "bad" sides. For the patient who already has a one-sided neglect, referring to that side of his body as "bad", only increases his negative body image.

Once a week, Sunnybrook provides a therapy group for stroke patients led by the occupational therapist and the author (a nurse). This is a five-week rotating program starting with a film illustrating how people cope with various disabilities. A member of the Toronto Stroke Recovery Association* visits and discussions follow on various aids that are available, the effects of the patient's disability on his lifestyle, and the various coping mechanisms others are using.

The family members are counselled throughout the patient's hospitalization on the best ways of supporting the patient, and they receive a booklet describing the rehabilitation of the stroke patient. Most patients go home with the occupational therapist for an afternoon. This time is used to assess the home for the patient's return and to offer suggestions for improvements. The patient then goes home for the weekend. This visit allows the patient and his family to practice what they have learned in the hospital. The home visit is followed by a family conference with the team, where problems, encountered in the home are discussed. The patient and his family need factual information as well as practical solutions to the problems that they are having. Gradually, the family learns about the various deficits the patient may have besides the obvious ones of hemiplegia and aphasia.

The patient may have problems judging the passage of time and the family should make use of clocks, radio, and television to assist him. He may have difficulty judging distances, e.g. from the table to the chair; and the use of verbal directions, keeping the furniture to a minimum, and not moving it unless necessary will be helpful. The patient may have unilateral neglect of his affected side and may need to be reminded to watch his positioning. He could have homonymous hemianopsia and thus be unaware of any objects or activities past the midline toward the affected side. If the patient is emotionally labile and begins crying for no apparent reason in the middle of a sentence, the family needs to know that he has no control over these outbursts, and that it is better to ignore them and keep on talking. Drawing attention to the outburst only prolongs it unnecessarily.

Most patients continue to receive occupational therapy or physical therapy either in their home or at a rehabilitation center as an outpatient. The patient and his family are also taught the warning signs of a stroke[8], including:

— sudden, temporary weakness or numbness of the face, arm or leg
— temporary difficulty or loss of speech, or trouble understanding speech
— sudden, temporary dimness or loss of vision, particularly in one eye
— an episode of double vision
— unexplained headaches, or a change in the pattern of headaches
— temporary dizziness or unsteadiness
— recent change in personality or in total ability.

Summary

At Sunnybrook, the creative process of rehabilitation is carried on throughout the patient's hospitalization. The patient and his family have been through a teaching-learning process involving all the members of the multidisciplinary stroke team. Because a stroke affects each person in a unique way, the stroke team has also learned from the patient— we have acquired more knowledge about a stroke, and have found more alternatives for solving problems.

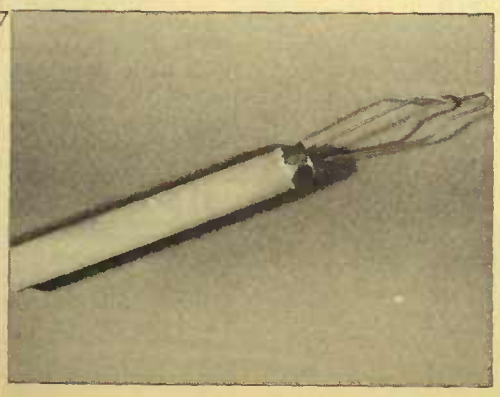
When the patient is discharged from hospital, he takes with him the *beginning ability* to adapt to his disability.

Linda Graham (B.Sc.N., University of Toronto; M.S., Ohio State University, Columbus, Ohio) is clinical nurse specialist in rehabilitation at Sunnybrook Medical Centre, Toronto.

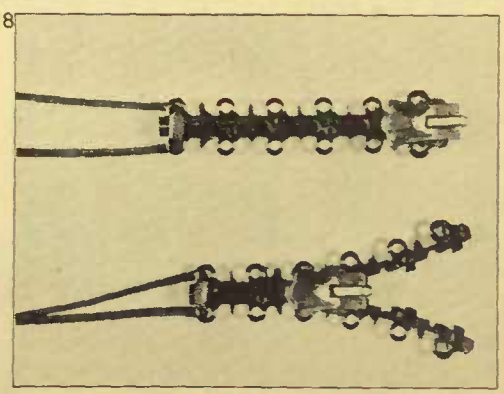
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** The T.S.R.A. is composed of stroke victims and professionals who provide recreation, socialization, support and dissemination of information to other stroke victims and families.*

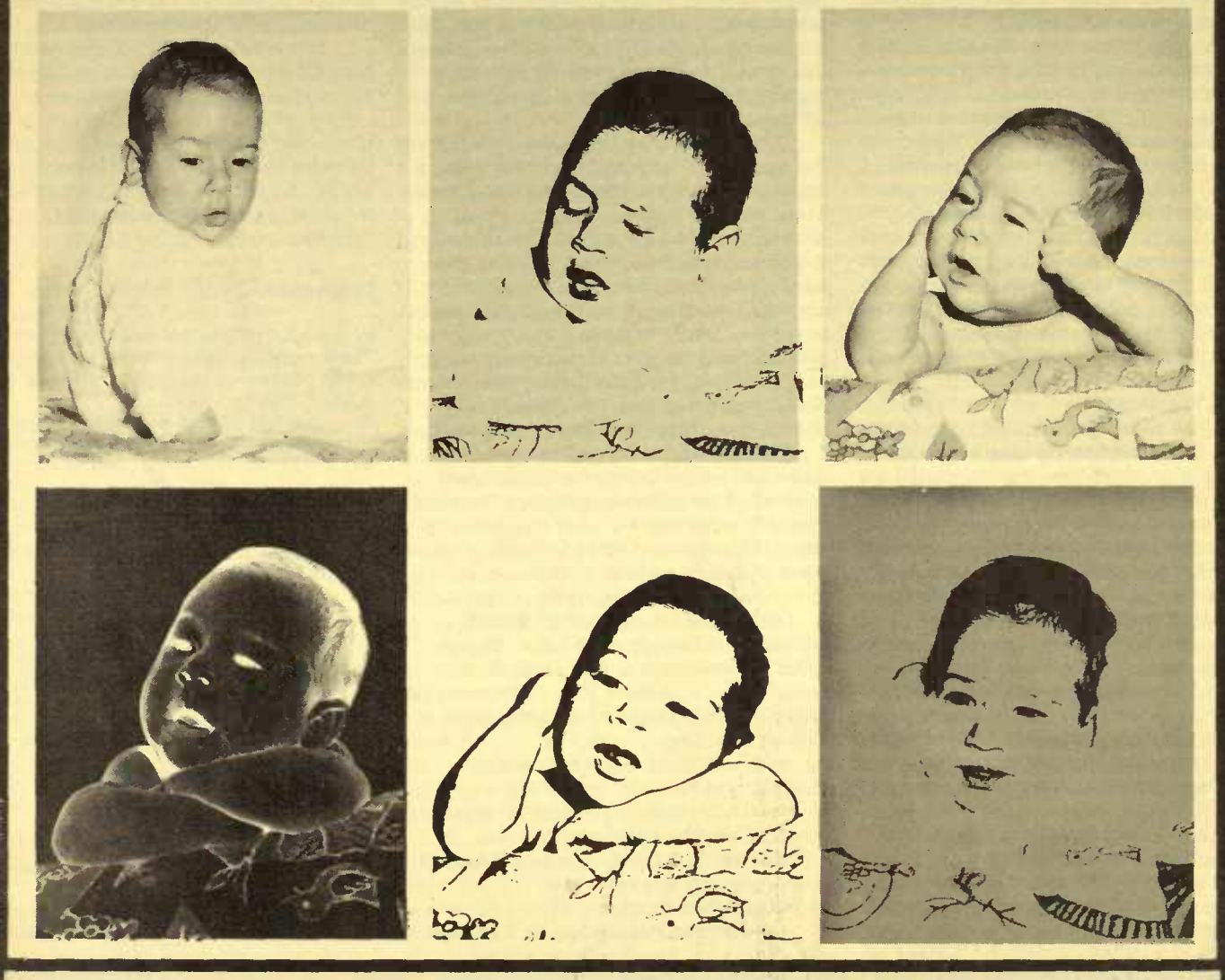


18



Viewpoint

What are the bonds between the fetus and the uterus?



Because of her role as a provider of health care, the nurse's involvement in the debate on abortion may be greater than she thinks.

Vincent W. Adamkiewicz

In order to discuss the biological aspects of abortion it is well, first, to distinguish between abortion and the various methods of birth control, as follows:

- Birth control methods *prevent*, by natural or artificial means, the union of the male sperm with the female ovum at a time when the woman is not pregnant and when there is no fetus.
- Abortion on the other hand, is an *extirpation* or *removal* of an existing fetus from a woman who is pregnant precisely as a result of the union between a sperm and ovum. Far from preventing conception, an abortion cannot take place *without* conception. It appears therefore, to be rather beside the point to argue in favor of abortion by appealing to arguments and reasons which are really concerned with birth control, family planning or the spacing of children.

Woman's right over her own body

"A woman's right over her own body" could be called upon in support of abortion in those cases where pregnancy resulted from parthenogenesis. This is a biological phenomenon in which the ovum develops into a fetus without an intervention of male sperm. Because of the genetic laws that govern the inheritance of sex, a woman's parthenogenetic babies would all be girls. Parthenogenesis is relatively easy to show, for example in rabbits. But in spite of the affirmations of some specialists, parthenogenesis among women is probably as rare as the Immaculate Conception. In any case, the two historical examples of human birth without male intervention, first cited apparently in Buddhism and later in Christianity, could not have been parthenogenetic because they produced boys. Nevertheless, Buddha's sex is uncertain, since this personality is variously depicted as male, female or neuter.

Normal pregnancies occur as a result of fertilization of the mother's ovum by the father's sperm. Consequently, the fetus is as much the "father's body" as the mother's. Therefore, the saying:"a woman has a right over her own body" loses much of its meaning when applied to the fetus and used as an argument in favor of abortion. The least a pregnant woman could do before ridding herself of the fetus is first to find out the father's wishes in the matter if at all possible.

The genetic message

The main discussion on abortion, however, concerns an entirely different question: "Is the fetus a human being?" Because if the fetus is not a human being, its extirpation by means of an abortion merely becomes one more simple surgical operation. On the other hand, if the fetus is a human being, the act of terminating a human life by extirpation falls under the provisions of the Criminal Code.

Let us examine this question in reverse, beginning with the end, which is birth, and ending with the beginning of the pregnancy, which is the fertilization of the ovum by the sperm.

A newborn child, that is a fetus delivered after a full term or even prematurely, is a human being in all respects. Who would dare to consciously deprive it of life? Our conviction in this matter rests mainly on its anatomical resemblance to other human beings. If physiological resemblance is a criterion, we find, for example, that a two-month-old fetus already has a brain which emits brain waves (E.E.G.), and that a 20-day-old fetus has a heart which beats (E.C.G.) as in other human beings. Indeed, it is quite possible to study the nine months of fetal life by means of the various disciplines of biology, from the most macroscopic (anatomy) to the most microscopic (molecular biology), and show that, at each instant, the human fetus displays innumerable human characteristics: physical, chemical and biological.

Indeed, the difficulty a biologist encounters when retracing in reverse the life of the fetus is not in finding out that each instant it is a human being. Rather, the difficulty lies in establishing, at the very beginning of its existence, the fraction of the second, the electrifying moment, when the new individual is not yet!

The male sperm and the female ovum carry within their nuclei a complete message containing all the information required to create a new human being. This genetic message is recorded on ribbons (chromosomes) by means of a special substance (nucleic acid) and in the form of various chemical molecules.

Nevertheless, neither the sperm nor the ovum yet constitute new human individuals. They are still part of the father and of the mother, and carry their genetic messages.

Is it during fertilization, when the message in the sperm combines with the one contained in the ovum, that a new human being is born? Is birth a rearrangement of what already exists to produce something which did not exist a while ago? This newly conceived being is undoubtedly like its mother, since it carries all her message. It is also like its father, because it also carries his message. At the same time it is very different from both parents because its own message is a combination of the other two. This is the great paradox of which life is made: how to be different while at the same time remaining identical.

The combined genetic message regulates the development of the human being during all the various stages of its life: fetal, infancy, adulthood and old age. It governs inexorably the form it will take, its bodily functions and its behavior.

Gregor Mendel demonstrated by experimenting with peas how the genetic message regulates the form of living things. In the century since, many others have demonstrated the universal importance of the genetic message on the functions of all living beings, ranging from viruses to man. In 1973, the Nobel Prize was awarded to Lorenz, Tinberger and Frisch for their demonstration of genetic controls over the behavior of vertebrate animals.

Nevertheless, genetic control itself cannot escape the biological "difference-identity paradox." This is because, while transmitting the inexorable identity from one generation to the next, the genetic message continues to to be "flexible." Indeed, each biological birth is necessarily and always accompanied by variations in the inherited resemblances (genetic variation). (Thus, "although the eyes of all women are beautiful, how much more so are the eyes of my beloved").

The triad: form, function and behavior, is not, however, enough to describe a human being. This is because, unlike other living things, man thinks. He has the ability to conceptualize.

Of all the various human attributes, should the ability to conceptualize or think alone lie outside the control of the genetic message? Reason makes this difficult to accept. The founder of analytical psychology and psychiatry, Carl Jung, postulated the existence in man of archetypes, conceptual models which we need not learn because we recognize them automatically. Jung never explained the origin of archetypes, in spite of being undoubtedly aware of the work on

What are the bonds...

heredity of animal behavior done by his contemporaries.

Would not the existence of a material link between the genetic message (heredity) and the archetypal conceptualization constitute a molecular basis for man's conscience and, who knows, perhaps even for his idea of a Supreme Being? Should indeed such a link exist , it will undoubtedly be demonstrated sooner or later. We can only hope at present that the fetuses which have inherited the appropriate combination of genetic messages and have undergone the genetic variations necessary to elucidate this relationship will not have been aborted in the meantime.

How to reconcile the rights of three separate beings?

The mother's uterus is a special reproductive organ within which the fetus develops.

What is not known generally is that the uterus also protects the fetus against possible harm from its mother, since the fetus, which is partly the father's body, constitutes a foreign tissue for the mother. Were it not for the uterine protective barrier, the mother would experience an allergic reaction against the fetus. Her body would destroy and reject it, as it destroys and rejects any implanted foreign tissue, be it a piece of skin or a heart. In fact, some of the so-called spontaneous abortions are caused precisely by such an allergic mechanism.

Similarly, the mother's body constitutes a foreign tissue for the fetus. Were it not for the uterine protective barrier, the fetus would experience an allergic reaction against the mother. It would attempt to destroy and reject her, as it destroys and rejects any foreign tissue after it is born. This capacity of the fetus to experience an allergic reaction against its mother may be the most striking example of its biological individuality.

Thus, the pregnant uterus is a very special organ. It belongs to the mother, of course, but it also contains another individual, the fetus. Moreover, this other individual is composed, in part, of the father's body and of his genetic message. Consequently, it belongs as much to him as it does to the mother.

Three individuals therefore, seem to have claims on the pregnant uterus: the mother, the fetus, and the father. Why then, under the circumstances, should only one of them make the awesome decision regarding the life and death of the new individual?

Would it not rather seem more appropriate to protect the pregnant uterus from such arbitrary decisions by granting it a certain extraterritorial status with respect to its mother's body and by surrounding it with the protection of the community?

Vincent W. Adamkiewicz, professor of immunophysiology, Department of Microbiology and Immunology, Faculty of Medicine, University of Montreal.

This article also appears in the February, 1976, issue of L'infirmiere canadienne.

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Canadian Nurses' Association 1976 Annual Meeting and Convention

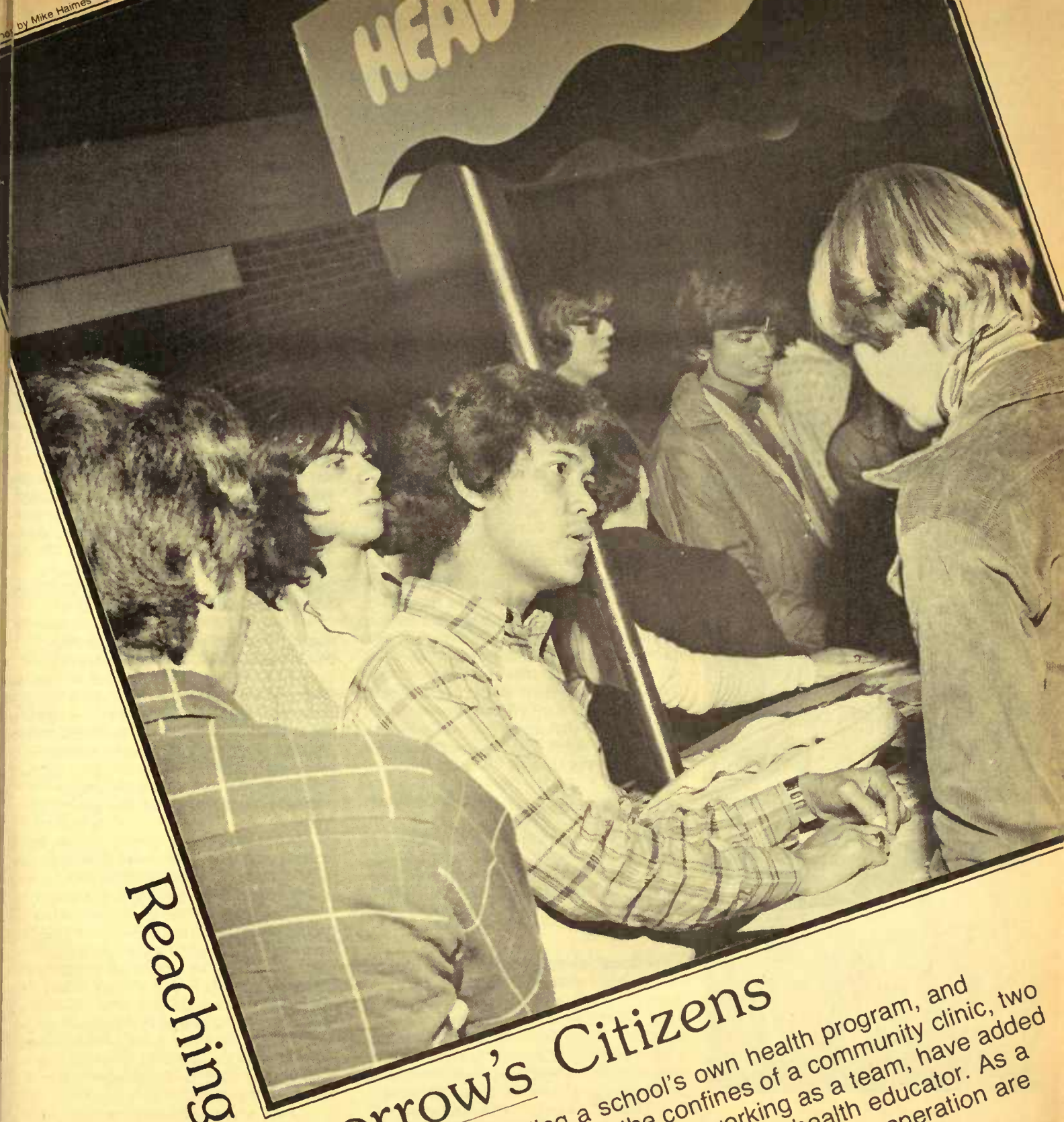
20-23 June 1976, Halifax, Nova Scotia

The 1976 Annual Meeting and Convention of the Canadian Nurses' Association will be held 20-23 June 1976 in the Commonwealth Room of the Hotel Nova Scotian, Hollis Street, Halifax, Nova Scotia.

The opening ceremony will be held on Sunday evening, 20 June 1976 at 19:30, followed by a reception for members, students and guests registered for the meeting. Business and interest sessions will commence at 08:30, Monday 21 June 1976, continuing daily and concluding Wednesday, 23 June 1976 at 19:30 with the President's reception.

Students enrolled in schools of nursing in Canada may register to observe the proceedings of the Annual Meeting and participate in interest sessions and social events.

by Mike Haimes



Reaching Tomorrow's Citizens

Liv-Ellen Lockeberg

By extending a school's own health program, and reaching beyond the confines of a community clinic, two Montreal-based nurses, working as a team, have added a new dimension to the role of health educator. As a result, the health horizons of another generation are being substantially broadened.

Reaching Tomorrow's Citizens





Two nurses from the Head and Hands Clinic in Montreal are teaching health "where it's at" to the young people in their community — at the local high schools and community colleges (CEGEPs). They are the second team of Head and Hands health educators to carry this type of program into the schools of Notre Dame de Grace (NDG) in west-end Montreal. The Clinic that serves as their home base was established four years ago to meet the needs of the youth community in this area of the city. Since then, the orientation of the clinic has changed from a drop-in center for crisis intervention and drug counseling to a comprehensive health center for all ages.

Head and Hands operates on funds provided by the federal government through the Non-Medical Use of Drugs Directorate.* Lawyers, dentists, doctors and other professional volunteers donate their services to Head and Hands without charge, although doctors do benefit if patients subscribe to Medicare. Paid personnel include the administrator, medical coordinator, counselors, health educators, nurses and office staff. Clients are asked to pay a nominal fee for tests and some services, if they can.

An apartment over a shop next to pocket-sized Echo Park on Montreal's Sherbrooke Street West houses Head and Hands. Furniture and equipment are donated, as are many of the medical supplies. Much of the literature on the waiting room's information shelf is obtained free from government agencies, associations, food producers, and insurance companies. Succinctly-worded posters on the walls are made by the staff. A notice board has been posted for the convenience of clients.

In four years of operation, the clinic has come to serve more and more the general health needs of the young, and not so young, of NDG. The young come for counseling on drug and alcohol abuse, and family planning, for pregnancy tests, legal counsel, dental advice, and nutrition tips. The older segment of the population look to the clinic for the last three services.

Hands reaching out

As most of those using the clinic are under 20, it follows that many attend school. Thus, when the school nurse at nearby Dawson College asked the clinic to present a program on birth control to her students some time ago, the invitation was welcomed as an opportunity to extend the clinic's services.

Then, in October, 1973, the health educators, (at that time Elizabeth Best and Jane Turner), set up their first health display of pamphlets, samples of contraceptives, and a model of female reproductive organs. They decided to place their display tables just outside the cafeteria of the Selby Campus of Dawson College, where they hoped students would drop by on their way to and from lunch to look, ask questions, and ask for advice. The response was so encouraging that now, two years later, the health workers of Head and Hands spend most of their working day among the students at five CEGEPs and several high schools in NDG. They are, however, still on the Head and Hands clinic staff.

The first year of entry on the school scene was devoted mainly to developing a worthwhile program to dovetail with the efforts of nurses in the CEGEPs; preparing brochures, displays, and posters; obtaining educational materials and samples from producers; and coordinating suggestions from interested students.

High schools

In the beginning, it was difficult to reach high school students. The two nurse-organizers wrote letters, and telephoned school principals and administrators of NDG only to receive no response, or the negative ones of "no time" or "not feasible." Nevertheless, they continued to prepare their battery of materials. It took a party to make everyone realize the clinic wasn't just for drug users and to generate active interest! In September, 1974, Head and Hands decided to hold a wine and cheese party. Formal invitations to high school teachers, nurses and counselors, and the school board of NDG brought nearly 60 visitors to the clinic to view the display of health teaching materials, tour the premises, and ask questions.

Then, in 1974-75, several high schools asked Head and Hands for supplementary health education. Certain class times were turned over to Bess and Jane to allow them to teach human awareness, family planning and preventive health in the two senior grades. When nutrition was the subject of discussion, students were encouraged to evaluate their own diets. Calorie counters, herbs to freshen the mouth, and nutritious snacks were handed out to add interest and generate dialogue.

In classes on family planning, Bess found working as a team with Jane to be especially helpful: dividing the responsibility for teaching and answering questions gave the sessions an air of informality and everyone gained confidence. Posters were used as a basis for reviewing the anatomy and physiology of human reproductive organs before going on to role playing. Bess or a student would play the role of a young girl and Jane that of the counselor. The dialogue that followed would cover what a birth control pill can and cannot do, how a doctor examines a patient, the questions he asks, and a demonstration of birth control devices.

Once, when demonstrating contraceptives, Bess inadvertently sprayed foam over the students in the front row! Laughter shattered any barriers that might have existed.

Students are concerned about birth control methods, their side effects, and failure rates. Because they want to avoid peer reaction they usually save their questions until after the class. Several have asked: "My girl friend and I use this method. How effective is it ?"

Not one hundred percent, evidently, for pregnancies do occur among the students and they usually follow a pattern, according to

* *At press time, continued funding from federal sources was in question.*

Bess. Girls notice missed menstrual periods in September and October, after summer holidays or in February after the Christmas vacation. This has prompted scheduling of birth control displays to just before the summer vacation and the Christmas break. The displays are simple and practical. Some of the titles are: "This is what happens in the doctor's office," "Questions the doctor will ask you," "This is a speculum."

Bess and Jane are no longer with Head and Hands, but their successors, Marg Hill and Marlene Fremming, are continuing to carry out the work they started and have built on the programs already established. Because of uncertainty about continued funding, they are also concerned about the future of their work in the community they are beginning to know.

One addition to the original program is a session on smoking and health that was introduced at the request of one of the area high schools. It is now offered to 21 first year classes in two high schools. The students do breathing exercises as they learn the facts about smoking. A smoking machine is used to demonstrate the effect of smoking on the lungs. Marg and Marlene play down the danger of cancer, which means little to these 13-year-olds, but do emphasize the need for them to ignore peer pressure.

Nutrition, dental care, and smoking are the main topics covered in this grade; family planning and venereal diseases are presented only to the more senior high school classes. "One school wanted us to include a lower grade in our birth control and VD programs," said Marg, "but we are not ready for that yet. We would have to do a lot of research to adequately reach these 11-and 12-year-olds and at the same time to feel comfortable in our own roles."

CEGEP program

In the CEGEPs, with up to 3,500 students, the bi-weekly health teaching program has to be informal. The original decision to present it at the busiest spot in the school, near the cafeteria, has proved sound. During lunch break, students cannot miss seeing Marg and Marlene at Head and Hands' "Healthy Rider" booth at Selby Campus or at their pamphlet-laden table at other schools. Judging from the responses on evaluation questionnaires, students like this casual approach and benefit from the educational materials and informal discussion of their problems.

Each two-hour,noonday session is devoted to one subject, which may be drugs, heart disease, nutrition (including vegetarianism and snacking), dental care, or family planning. Other topics being prepared are stress, exercise, and ecology (pesticides and the environment).

The CEGEP health nurses work closely with Marg and Marlene when planning programs by holding workshops and securing speakers and films to enlarge on the subjects dealt with at the displays. An example of cooperative effort is the Fitness Fair presented in the cafeteria area twice a year. The fair on heart disease, for example, involves the dietetic and athletic departments of the school as well as Marg and Marlene.

Dietitians are at their display table and are available for individual guidance on weight reduction and low cholesterol diets; the physical education instructors conduct tests for fitness on students riding stationary bicycles; and the health educators and school nurse take blood pressures and test vital capacity of the lungs. The multidisciplinary program helps to get across the idea that an individual's state of health is the result of many interrelated factors over which he has some control.

Experience has shown that the fitness of CEGEP students generally is not up to the level expected of this age group. For instance, in the bicycle test, where students pedal a stationary bicycle at 60 strokes per minute, there are few who reach the 80% mark (upper 20% of population are considered fit) and too many who fall below the 40% level of fitness.

Blood pressure is usually normal among the students, but when the systolic pressure reaches 130-140, they go to the dietitian's booth to be weighed and to discuss nutrition. They are referred to a physician for a more thorough checkup; many end up at the Head and Hands clinic for that.

One student beamed with pride at having lost 15 pounds and hoped that his blood pressure would be down too. It was, but not enough to allow him to abandon his prescribed diet and exercise regimen. With encouragment and reinforcement from the nurses, he will probably eventually reach normal limits and regain a feeling of well-being.

Conclusion

The objectives that emerged during the first year of the program's operation are still applicable to the current, expanded program:

- to help increase young people's awareness of health care, especially its preventive aspects
- to encourage the young to adopt healthful lifestyles
- to motivate young people to assume a more active role in their own continuing health education
- to make health education an enjoyable, relaxed nursing experience.

Most important, informal liaison with school health personnel and flexibility allow the program to meet the changing needs of the young population served. In the future, it is hoped to increase the effectiveness of the program even further, by involving students in planning their own care program through a health council.

Elizabeth Best (R.N., Montreal General Hospital school of nursing; B.A., Concordia University, Montreal) is now studying full time toward a B.Sc.N.

Jane Turner (R.N., Montreal General Hospital school of nursing; B.A., Concordia University, Montreal) is with the federal government's medical services in British Columbia.

Marlene Fremming (R.N. Montreal General Hospital school of nursing) and Margaret Hall (R.N., Montreal General Hospital school of nursing; B.N., McGill University, Montreal), are the present health educators at the Head and Hands Clinic.

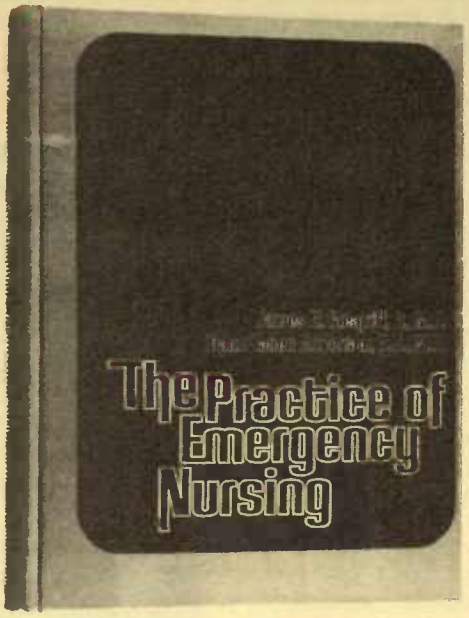
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ENJOY
HALIFAX
FOR WHAT IT IS
AND FOR WHAT IT WAS

Dorothy Miller

This oldest English city in Canada, founded in 1749, has cherished and preserved its history while becoming very much a city of this century. High-rise office and apartment buildings with clean modern lines contrast sharply with the grace and architectural elegance of the commercial and residential structures of another day. Scotia Square in downtown Halifax is a $65 million complex of residential, retail and commercial facilities. When completed, it will be the largest concrete structure in North America. On the waterfront, just below this towering complex, is the *Restoration of Historic Waterfront Buildings* project that includes some of the oldest maritime buildings still standing in Canada.

The site has now resumed much of its nineteenth century appearance and is an exciting place to visit. The choice of quality shops and boutiques is wide. There's *L'Entrepot* — contemporary designs in everything from chairs to cutlery; *The Pewter House*, handcrafted designs from the Maritimes; *The Doll House*, a delight to children, rich uncles and loving grandmothers; and *Nova Pine* where you'll find reproductions and heritage crafts, quilts etc., of Nova Scotia. *The Duke of Granville*, a 19th century restaurant, is here too, as well as the studios of the Nova Scotia College of Art and Design.

Closer to the waterfront is *Privateers Warehouse*, the long, low, rough-cut gray stone building that forms the core of the waterfront restoration. It dates from the profitable privateering activities of Nova Scotians during the Napoleonic Wars and now houses a pub and two seafood restaurants.

Browse through *A Pair of Trindles in the Old Red Store*, a book shop specializing in Canadiana and books on Nova Scotia, *The Merchant Adventurers*, featuring the work of Nova Scotia artisans, *The Sea Chest on the Wharf*, *The Wooden Store* and *Sailloft*. Then, stop for a giant ice cream cone or a hearty sandwich at *Scoops* in *The Carpenter Shop* and eat it out on the wharf while you watch the swaying masts of the Bluenose, last of the "tall schooners," the harbor traffic and ironwork tracery of the two harbor bridges.

There are four ways to see Halifax:

- ***By car:*** Competent guides can be obtained through the Halifax Visitors and Convention Bureau. Follow the Kingfisher Route signs throughout the city, or use your Metro Guide. This has an excellent description of historical and interesting sights.
- ***By bus:*** Both the Halifax Transit Corporation and Gray Line have sightseeing tours. Passengers are picked up at Holiday Inn, Citadel Inn, Chateau Halifax, Lord Nelson and Hotel Nova Scotian.
- ***By water:*** Halifax Water Tours provides a complete tour of the harbor and the Northwest Arm. Or, see Halifax from the water on the Dartmouth Ferry.
- ***By foot:*** If you like walking, the 45-minute tour of old Halifax is for you. Take your Metro Guide or the Walking Tour Guide provided by the Visitors' Bureau and start off from the Citadel. You'll enjoy the sense of history all around you, catch the views of what has been called the finest natural harbor in the world, and perhaps stop at *The Five Fishermen*, located in the oldest school building in Halifax and famous not only for its food but also for its stained glass decor. The building dates from 1818 and was at one time an art school under the direction Anna Leonowens, famed governess of the King of Siam.

Halifax can also be a relaxing city with plenty of places to sit on a park bench and dream. Almost in the middle of the city is the Public Gardens, 17 acres of "green survival," including botanical gardens, ducks and swans, and wild birds nesting around a large pond. The Band Stand, where free band concerts are given on summer Sunday evenings, was erected in 1887 to honor Queen Victoria's Golden Jubilee.

Point Pleasant at the extreme south end of the city features 186 acres of woodland, a free supervised swimming beach, a nature trail, footpaths, picnic tables, and places to build a fire for a barbecue, within sight of the sea.







Art galleries and museums, an abundance of them, are also yours to enjoy in Halifax. The three universities in the city, Dalhousie, Saint Mary's, and Mount Saint Vincent all have art galleries with active exhibition programs. These are supplemented by the new Gallery of the Nova Scotia Museum of Fine Arts (soon to become the Art Gallery of Nova Scotia), the Centennial Gallery at the Citadel, and three commercial galleries, including Zwicker's, founded in 1886. The Nova Scotia Museum on Summer Street near the Commons, is very much a part of the city's and the provinces cultural, scientific and historical life. This museum also has a History Branch on Citadel Hill. Interested in trains? The Scotian Railroad Museum is the depot for railroad enthusiasts. You'll find it on Mumford Road near the CNR main line.

Halifax has many good eating places. "One of the ten best in Canada" says the Toronto Star of Fat Frank's *Proof of the Pudding* restaurant on Spring Garden Road It is superlative food, superlatively cooked by Fat Frank himself. Another "dinner only" spot is the *Night Watch* at the Chateau Halifax. Here you will find a beautiful view, excellent food, and lovely music for dancing. The *Henry House* and *The Little Stone Jug* are two equally good restaurants, just three minutes' walk from the Hotel Nova Scotian, in the old stone house of the Hon. William A. Henry, a Father of Confederation, at 1222 Barrington Street. There's *Chez Jean* on South Park Street and *L'Hermitage,* and *The French Casino.* on Gottingen for really fine French cuisine, *The Heidelburg* for hearty German fare, *Mario's* and *The Gondolier* for pasta at its best, *The Maharaja* for curries, *Zapata's* for Greek and Mexican specialities, and many well-recommended Chinese restaurants, including *China Town,* which is right on the water at Bedford Basin.

"Down east hospitality" is waiting for you. Come to the Convention in Halifax — fall in love with all Nova Scotia—stay for three days and you'll become a member of the "Order of Good Cheer," with a certificate to prove your membership in this oldest social club in the New World. But we hope you'll stay much longer — and we know you'll have the time of your life.

If you'd like more information or have questions, write the Nova Scotia Department of Tourism, Travel Services, Box 130, Halifax, Nova Scotia. The following publications are also available for the asking — Accommodations and Campgrounds — Highway Maps — Events Calendar — Nova Scotia Holiday — Fish Nova Scotia's Saltwaters — Fish Nova Scotia's Freshwaters — Hunt Nova Scotia — Golf Nova Scotia — Dive Nova Scotia — Tour Nova Scotia.

An Invitation To Student Nurses

The Student Nurses' Association of Nova Scotia joins with the Nova Scotia members of the Canadian University Nursing Students Association in extending a warm welcome to nursing students from across Canada. You are invited to participate in the activities planned especially for students during the Canadian Nurses' Association Convention.

There will be an informal social evening on June 20th at St. Mary's University where accommodation at reasonable rates will be available for students.

On the evening of the 22nd of June there will be a supper and a "Barn Dance". We look forward to welcoming student nurses with "down east hospitality."

For information: Sister Sharon Young, President S.N.A.N.S. Halifax Infirmary, Halifax, N.S. — John Dow, National Chairman, C.U.N.S.A., 6829 Vaughn Avenue, Halifax, N.S.

RNANS Tentative Social Program for CNA Convention 1976

Sunday Night — June 20

Welcome to Nova Scotia Punch Party — with musical entertainment to be held immediately after opening ceremonies, at the Hotel Nova Scotian. Rum punch and plain fruit punch with cold hors d' oeuvres will be served.

Monday and Tuesday Nights — June 21 and 22 — choice of:

Lobster with Laughter — Lobster dinner and Ceilidh — pronounced Kalley — a Ceilidh is a gaelic word meaning a get-together with music, singing, dancing and lots of laughter.

Tour to Peggy's Cove ending at the Shore Club in Hubbards, by the sea, for a lobster dinner*and musical entertainment.

Water Tour of Halifax Harbor ending at the Clipper Cay Restaurant on Privateers Wharf for a Shore Dinner.

*Alternative menu available

Dorothy Miller is the Public Relations Officer for the Registered Nurses' Association of Nova Scotia.

Post-Convention Tours

4-day tour of mainland Nova Scotia including Cape Breton where you will see the fortress of Louisbourg and the Alexander Graham Bell Museum at Baddeck. Cross romantic Cape Smokey to Cape Breton Highland National Park on the Cabot Trail and visit the Miners' Museum. Enjoy the spectacular scenery.

6-day tour of Nova Scotia, Cape Breton and Prince Edward Island, visiting Oak Island, Lunenburg, Habitation at Port Royal, Grand Pré. Taking the ferry from Cape Tormentine to Prince Edward Island, visit Summerside, Charlottetown, Anne of Green Gables Museum, Cavendish Beach and then see Cape Breton, the Cabot Trail, Louisbourg and Baddeck.

Air-conditioned motor coaches are used for the tours and a qualified tour director will accompany each one.

For further information write: Nova Tours Limited, P.O. Box 1555, Halifax, N.S. Tel. — 902-429-3702

Toronto General Hospital graduates are invited to get in touch with Mrs. J. F. Rafuse, 22 Piers Avenue, Halifax, to indicate their attendance at the CNA Convention in Halifax. The graduate nurses from this hospital who live in Nova Scotia will be arranging a special get-together.

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Photos courtesy Nova Scotia Communication and Information Centre.

1 Princess Louise Fusiliers, Halifax Citadel.
2 Aerial view Halifax Waterfront.
3 Privateers' Wharf (restoration project) Halifax.
4 Handicraft boutique, Halifax.
5 Church at Grand Pré commemorating Acadian expulsion.
6 Surf near Peggy's Cove.



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Names and Faces

Gladys Sharpe, a former president of the Canadian Nurses' Association and of the Registered Nurses' Association of Ontario, died in hospital November 18, 1975 after a lengthy illness.

After a 42-year career that spanned active nursing, teaching, administration, and military wartime service, Sharpe retired in 1968 as senior nursing consultant on operating standards with the Ontario Hospital Services Commission to work with kindergarten children.

Among her career assignments have been those of director of nursing, Toronto Western Hospital; World War II, matron of the RCAMC Hospital at Camp Borden and liaison officer for the Canadian, British, and South African army medical services; and director of the school of nursing at McMaster University in Hamilton.



Vivian MacDougall (R.N., Sacred Heart Hospital school of nursing, Havre, Mont.; Dipl. Teaching and Supervision, U. of British Columbia) has been appointed nursing coordinator for the New Brunswick Association of Registered Nurses. She has held general staff and head nurse positions in Saskatchewan, Washington, California, and with the Royal Canadian Navy. She worked as a clinical instructor in Ontario before moving to New Brunswick, where she held similar positions at the Saint John General Hospital School of Nursing and Victoria Public Hospital School of Nursing in Fredericton. MacDougall coordinated NBARN'S recent reorientation course for inactive nurses conducted at Victoria Public Hospital.

Senior nursing department appointments at the Lions Gate Hospital, North Vancouver, B.C. were announced a few months ago: **Joyce M. Campbell** is nursing director. A graduate in nursing from the Vancouver General Hospital school of nursing, she has diplomas in teaching and supervision, public health, and business administration from the University of British Columbia. She has held various nursing and teaching positions at the Vancouver General Hospital and, in 1967, joined the staff of the Lions Gate Hospital, where she has been supervisor in various departments, and nursing coordinator/director of nursing administration.

Jocelyn Howden (R.N., Vancouver General Hospital school of nursing; B.S.N., University of British Columbia) is assistant nursing director, responsible to the nursing director for the supervision of clinical functions of the nursing department. Her nursing career has brought her to Australia and Ontario. Since 1961 she has been on staff at the Lions Gate Hospital, as head nurse, supervisor, and nurse coordinator/director of clinical nursing.

Helen Graham is assistant nursing director, responsible to the nursing director for the supervision of staff allocation and coordination with clinical requirements of the nursing department. She earned her nursing diploma at the Victoria Infirmary, in Glasgow, Scotland, and has studied nursing unit administration at the University of British Columbia, Vancouver. Before joining the nursing staff of the Lions Gate Hospital in 1966, she was on staff at the Toronto Western Hospital and the Victoria Hospital, London, Ontario.

The Alumnae Association of the Montreal General Hospital school of nursing has awarded 7 bursaries for post-basic education in nursing to its members for the year 1975-1976. Recipients are: **Susan Collins, Ellen Hennessey, Karen Finestone, Anne Mutz, Susan Burrows, Heather Ayerst Tyler** and **Susan Lindsay.** All are in the Bachelor of Nursing program at McGill University school of nursing, Montreal.

Alma Leclerc (R.N., St. Paul's Hospital school of nursing, Saskatoon) has been appointed program director of The New Brunswick Tuberculosis and Respiratory Disease Association. Her nursing experience includes general staff and head nurse positions at the Saskatchewan Sanatorium, with the Saskatoon Anti-Tuberculosis League, the Central Tuberculosis Clinic in Winnipeg, and the Royal Ottawa Sanatorium. She also worked for the Ontario Ministry of Health in Ottawa where she was a clinic nurse dealing with TB prevention, and the Sudbury and District Health Unit, with emphasis on community work.

Leclerc sees her new role as mainly educational, involving professionals and the public. One of her top priorities is to establish a nurses' section of the Association, as part of the educational program for professionals.



Judith M. Skelton (B.Sc.N., McMaster University, Hamilton; M.Sc.N., University of British Columbia) has been appointed coordinator of nursing education at Okanagan College, Kelowna, B.C. She has taught at St. Michael's School of Nursing, Toronto, The Vancouver General Hospital School of Nursing and the University of British Columbia. Most recently, she was employed as a public health nurse with the Central Okanagan Health Unit, Kelowna.

Okanagan College anticipates admitting its first class of RN students in September 1976. An LPN program is already established there.



Constance Swinton (R.N., Royal Alexandra Hospital school of nursing, Edmonton B.N., McGill University, Montreal; M.P.H., University of Michigan, Ann Arbor) has been appointed consultant with CARE/MEDICO in Solo, Indonesia. She is on loan for one year from the Canadian International Development Agency, which she joined a year ago. Her major function will be to work with CARE's country director and local authorities to plan and evaluate rural public health programs with a view to expanding and improving them.

Swinton has been director of education and projects at the national office of the Victorian Order of Nurses; public health consultant with child and adult health services, Health and Welfare Canada; and an assistant professor in the population unit, School of Hygiene, University of Toronto.

Mary Dohey (R.N., St. John's General Hospital, St. John's, Nfld.) has been awarded the Cross of Valor, Canada's highest decoration for bravery. On November 11,1971, as an Air Canada flight hostess she averted a major tragedy by spending eight hours pacifying a man, armed with a shotgun and dynamite, who had hi-jacked a DC-8 plane flying out of Calgary. He forced the crew to land the plane at Great Falls, Montana, where he obtained a ransom of $50,000. Dohey then persuaded him to let the plane land again at Great Falls to allow the 118 passengers and some of the crew to leave the plane.

Dohey has been a part-time nurse at St. Joseph's Hospital in Toronto and recently was awarded her 10-year nursing pin. ▶

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Edited by Matisyohu Weisenberg, Ph.D. July, 1975. 386 pages plus FM I-XII, 7" × 10¼", 86 illustrations. Price, $10.00.

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By Alice Lorraine Smith, A.B., M.D., F.C.A.P., F.A.C.P. April, 1976. Approx. 720 pages, 8" × 10", 563 illustrations, 2 full page color plates. About $15.70.

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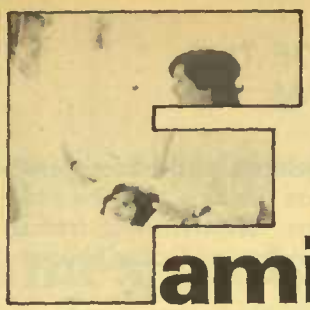
By Marcella M. Strand, B.S.N., R.N. and Lucille A. Elmer, B.S. in M. T., M.T.(A.S.C.P.). April, 1976. Approx. 104 pages, 5½" × 8½", About $5.75.

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By Lillian DeYoung, R.N., B.S.N.E., M.S., Ph.D.; with 3 contributors. April, 1976. Approx. 336 pages, 7" × 10", 14 photos, 29 illustrations. About $10.00.



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By Evelyn G. Sobol, R.N., A.M. and Paulette Robischon, R.N., Ph.D. June, 1975. 182 pages plus FM I-XVI, 7" × 10". Price, $7.90.



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By Wilbert E. Fordyce, Ph.D. February, 1976. Approx. 256 pages, 7" × 10", 25 illustrations. About $10.00.



Issues, education, administration

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By Austin Fagothey, S.J. April, 1976. Approx. 488 pages, 7" × 10", 1 illustration. About $13.15.

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By Jean E. Schweer, R.N., B.S., M.S. and Kristine M. Gebbie, R.N., M.N. February, 1976. 216 pages plus FM I-VIII, , 7" × 10", 3 illustrations. Price, $8.35.

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By Dolores F. Saxton, R.N., B.S., M.A., Ed.D. and Phyllis W. Haring, R.N., B.S., M.S., M.Ed. May, 1975. 110 pages plus FM I-VIII, 6" × 9", 8 illustrations. Price. $5.00.

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Names and Faces

Recent appointments to the faculty of the University of Alberta school of nursing include:

Joan Affleck (R.N., Royal Alexandra Hospital school of nursing, Edmonton; B.Sc.N., University of Alberta) lecturer, who was formerly with the Victorian Order of Nurses in Peterborough, Ontario;

Rene Day (R.N., B.Sc.N., University of Alberta school of nursing; M.S., University of Hawaii) assistant professor, who has been a public health nurse with the City of Calgary health department and a lecturer at the U. of Alberta school of nursing, Edmonton;

Sylvia King-Farlow B.Sc.N., University of Alberta; M.Ed., University of Ottawa) lecturer, who has had extensive nursing, supervisory, and teaching experience in hospitals in Edmonton, Los Angeles, Culver City, and Guelph;

Jane Ligowski (B.Sc.N., University of Toronto school of nursing), visiting lecturer, who has been a public health nurse in Midland, Ontario and staff nurse at the University of Alberta Hospital, Edmonton; and

Reita Markovich R.N., Victoria Hospital, school of nursing, London; B.Sc.N., University of Alberta) clinical supervisor, who has been engaged in general duty and public health nursing in London, Peace River, Port Alberni, Calgary, and Edmonton.

Claire Kane (R.N., St. Martha's school of nursing, Antigonish; B.Sc.N., University of Ottawa) has been appointed executive director of Planned Parenthood Ottawa, succeeding **Mary Mills** who has become executive director of the Planned Parenthood Federation of Canada in Toronto.



Marjorie Hewitt (R.N., Vancouver General Hospital school of nursing; B.A.Sc., University of British Columbia) has been appointed nursing consultant with the Saskatchewan Registered Nurses' Association. Formerly assistant director of the Regina Grey Nuns (Pasqua) Hospital school of nursing, she has also had extensive clinical and teaching experience with the Royal Inland Hospital in Kamloops, B.C., and the Regina General Hospital.

Nurses appointed during 1975 to the faculty of nursing at Dalhousie University, Halifax, include:

Shirley Halliday (R.N., Victoria General Hospital school of nursing, Halifax, B.N., Dalhousie University), lecturer. She was formerly instructor and curriculum coordinator at the Victoria General Hospital school of nursing, Halifax.

Judy Harwood (R.N., Toronto General Hospital school of nursing; Dipl. Public Health and Outpost Nursing, Dalhousie University), lecturer in outpost nursing. She has worked in the emergency department, Toronto General Hospital, and with the medical services branch of Health and Welfare Canada at Aklavik, N.W.T.

Ruth C. MacKay (B.A., McMaster University, Hamilton; M.N., M.A., Emory University, Atlanta, Ga.; Ph.D., University of Kentucky, Lexington, Ky.), associate professor. Since returning to Canada in 1969, Dr. MacKay has been associate professor at Queen's University, Kingston, and at McMaster University, Hamilton, Ontario. She has had articles published in several professional journals.

Hattie Lee Shea (R.N., Dallas Methodist Hospital school of nursing; B.S.N.Ed., M.S.N., University of Texas, Austin), associate professor. Her previous appointment was that of assistant professor, University of Western Ontario, London and, prior to coming to Canada in 1970, she worked in various centers in Texas.

Marilyn Walper (B.Sc.N., University of Saskatchewan, Saskatoon), lecturer. During her nursing career as staff nurse and instructor she has worked in Saskatoon and Moose Jaw, Saskatchewan; Barrie, Ontario; Portage-La-Prairie, Manitoba; and Dartmouth, N.S.

Leslie White (R.N., Montreal General Hospital school of nursing; B.N., University of New Brunswick, Fredericton; M.Sc.N., University of Western Ontario, London), lecturer. She has been on the nursing staff of the Sensenbrenner Hospital, Kapuskasing, Ontario; Montreal General Hospital, Montreal; Hotel Dieu Hospital, Perth, New Brunswick; and Victoria Hospital, London, Ontario.

Ardythe Wildsmith (R.N., Nightingale School of Nursing, Toronto; B.N., Dipl. Public Health, Dalhousie University), lecturer. She was formerly an instructor at the Victoria General Hospital school of nursing, Halifax.

Calendar

February 28 - 29, 1976
Post-Anesthetic Recovery — A Conference for Nurses, to be held at University of British Columbia, Vancouver, B.C. *For information write: Continuing Education in Health Sciences, Woodward Instructional Resources Centre, University of British Columbia, Vancouver, B.C. V6T 1W5.*

April 2 - 4,1976
Biennial meeting of the Northwest Territories Registered Nurses' Association to be held in Yellowknife, N.W.T.

March 24 - May 12, 1976
Course: "Recent Advances in the Nursing Care of the High Risk Pregnancy Patient and the Newborn Infant," Wednesday evenings at the McLennan Physics Building, University of Toronto. *For information contact: Dorothy Brooks, Continuing Education, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ont., M5S 1A1.*

April 5-9, 1976
Rehabilitation nursing workshop to be held in Edmonton. For information, write: Nursing Education Coordinator Glenrose Hospital, 10230—111 Avenue, Edmonton, Alta.

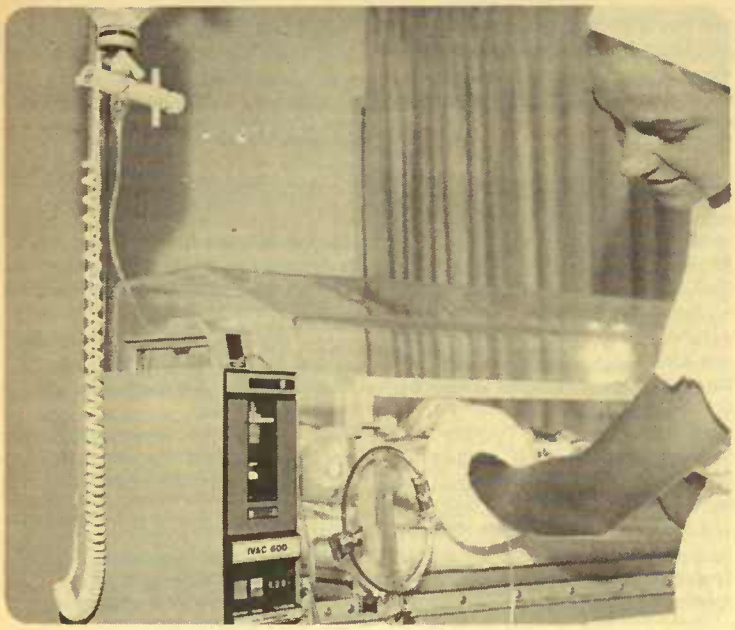
April 29 - May 1, 1976
Annual Meeting of the Registered Nurses' Association of Ontario to be held at the Royal York Hotel, Toronto, Ontario.

April 23 - 24, 1976
Interdisciplinary Respiratory Disease Workshop sponsored by the New Brunswick Tuberculosis and Respiratory Disease Association will be held at the University of New Brunswick in Fredericton, N.B. *For further information write: Alma T. Leclerc, Program Director, New Brunswick TB and R.D. Association, 123 York Street, Fredericton, N.B. E3B 5E3.*

April 19 - 23, 1976
Advanced refresher course for obstetrical nurses to be held at the School of Nursing, University of Alberta, Edmonton. *For information, write: Continuing Education for Nurses, 12-103 Clinical Sciences Building, University of Alberta, Edmonton, Alberta T6G 2G3.*

May 17 - 19, 1976
General Foods National Nutrition Seminar at the Toronto Hyatt Regency Hotel, a multi-disciplinary approach to nutrition. *For information, contact: Una Abrahamson, Co-ordinator, General Foods Nutrition Service, Suite 400, 4th floor, 2 Bloor Street West, Toronto, Ont., M4W 3K1.*

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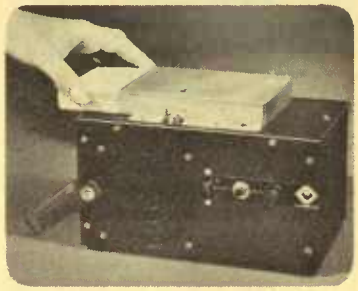
For further information, write: Convertors Division of American Hospital Supply Corp., 1633 Central St., Evanston, Ill. 60201, U.S.A.

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Books

Nursing the Dying Patient by Charlotte Epstein. 210 pages. Virginia, Reston Publishing Co., 1975.
Reviewed by Betty Johnson, Lecturer in Nursing, The University of British Columbia, Vancouver, B.C.

In the past ten years, the literature concerning the care of the dying patient has gone from next-to-nothing to remarkable in quantity (and, usually, in quality). The hard work and compassionate attitude of Elisabeth Kübler-Ross is an outstanding example of bringing to our awareness the personal needs we all have in facing death — our own and our patients'. Western society has encouraged us to deny death. In order to avoid running from our dying patients we have to face our fears about death.

The literature cries out against abandoning the patient, but we are still left with the task of how to actually get ourselves into the *real* situation with our patients and their families. Charlotte Epstein's book *Nursing the Dying Patient* tries to help student and teacher (and in the author's approach these roles are always interchangeable) bridge the gap between theory and practice. Her objectives are to have us learn to face our own dying and learn to interact with dying people.

The strength of the book rests in the way Epstein has provided the reader with a rich variety of exercises, role-play situations, practice interactions, and thought-provoking questions. This book is not to browse through, rather it is a book to be worked through in a small and supportive group. It contains a gold mine of activities outlined in specific detail and with a firm theoretical base. A group working with this book will get in touch with the myriad of emotions encountered when facing death and will also have the practice needed to confidently enter nurturing relationships with dying patients.

Clinical Nursing 3ed., by Irene Beland and Joyce Y. Passos. 1120 pages. New York, Macmillan, 1975.
Reviewed by Basu Majumdar, Assistant Professor, School of Nursing, McMaster University, Hamilton, Ont.

This book is an improvement over the first and second editions.

The authors have used patient-centered and problem-solving approaches. The book deals with the basic sciences necessary to understand "pathology."

Most of the 19 chapters are comprehensive and include anatomy, physiology, biochemistry and family oriented patient care including the acute, chronic, and rehabilitative stages. The "psychosocial impact of illness on a patient" and the spiritual needs of a patient are emphasized by the authors.

In the preface, the authors explained that they have reorganized and updated the content of the book. They have attempted to demonstrate the importance of nursing intervention in the clinical setting and also the importance of applying basic science principles to a variety of nursing situations.

Focus is placed on the promotion of health, the prevention of disease, the medical treatment and nursing care of people with illness, and the differences between health and illness. The case studies are very helpful and they provide opportunities to discuss and understand the dynamics of various biopsychopathologies. The book is organized and begins with physiology, injurious agents, and responses of the body to injury. The major focus is then given to specific problems in clinical settings. The illustrations and diagrams are helpful and the reference materials that are included at the end of each chapter are current and comprehensive. Most of the common and current clinical conditions are treated by the authors.

The discussion on 'Pain' is given in detail and the important points are highlighted. The chapter "Summary of Some Responses to Injury" is well explained and organized.

"Nursing the Patient Having a Problem with Some Aspect of Transporting Material To and From Cells" is an excellent and comprehensive chapter. Anatomy; physiology; assessment of the patient with different conditions, e.g., anemia, venous and arterial problems during therapy; diagnostic tests; surgery; and nursing interventions are included. Illustrations on page 672, are very helpful in understanding fluid retention in congestive heart failure.

"Nursing the Patient in Shock," another excellent chapter, includes the effects of shock on each body system and the responses by the systems. Causes of shock and "how may the degree of cardiovascular responses be determined" are explained well.

This reviewer believes that the book could not be used as a quick reference. The printing in this book is still distracting and the method of marking important points could be improved. However, it is a comprehensive text for the graduate nurse and an excellent basic text for baccalaureate nursing students.

Designing Hospital Training Programs by Reba D. Grubb and Carolyn J. Mueller. 199 pages. Springfield, Ill., Charles C. Thomas, 1975.
Reviewed by Sharon Richardson, Nursing Instructor, Selkirk Community College, Castlegar, B.C.

Essentially a handbook on "how to"; *Designing Hospital Training Programs* is rooted in the philosophy that a hospital-wide educational service is preferable to multiple, independently organized, and administered inservice programs offered by separate departments within the institution. The rationale presented by the authors states that "hospital-wide programs should be designed to improve patient care, thereby, reaching the individuals involved, regardless of the department in which they work."

Guidelines for evolving a hospital-wide educational program, including a basic overview of learning theory, are presented in the first half of the book. Included, are suggestions for the use of instructional material, a description of selected teaching methods and teaching aids. A discussion of the formal organizational component required by a hospital-wide educational program, is introduced in the first chapter. However, this aspect is not developed.

The second half of the book is devoted to sample program outlines, or "modules." These modules are presented in some depth since "the authors hope that they may act as a guide to establishing and expanding training programs on a hospital-wide basis."

At intervals throughout the first half of the book, the authors indicate that they perceive the role of a hospital education program as being considerably broader in scope than simply to serve hospital needs. For example, mention is made, on pp. 15 — 16, of hospital sponsored classes that "eliminate basic educational deficiencies and lead to a high school diploma." In light of existing educational resources for upgrading, e.g., high school, adult learner classes, and college preparatory programs, duplication of services by the hospital seems unjustified.

Essentially, the authors appear to have achieved their stated goal of presenting in a single volume the synthesized elements of a hospital-wide educational program. Unless one is employed as an educational coordinator in an institution that uses this approach to inservice, the most informative aspects of the book would probably be chapters 2-4. The steps that are involved in planning and implementing a particular inservice program are discussed here.

This book cannot take the place of existing texts that deal with theories of learning or methods of instruction. However, it could serve as an adjunct in the development of specific, instructional programs. Nursing coordinators, in particular, might find it a useful guide to supplement other standard texts and articles.

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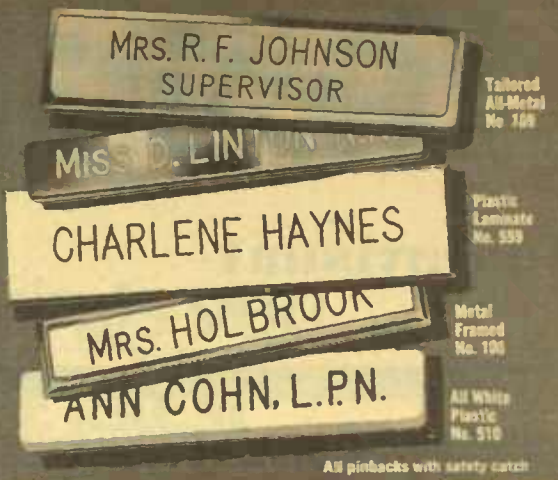
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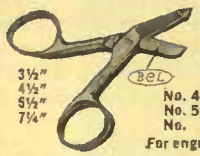
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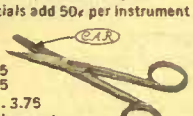


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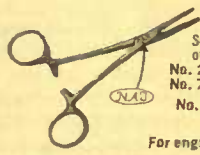
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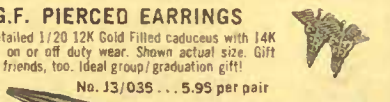


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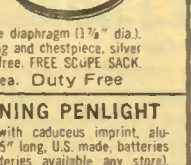
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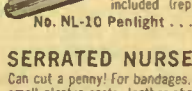
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Purposes of Family Planning

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About Conception and Contraception

This is a 12 min. color film illustrating reproductive physiology, sexual intercourse, conception, and methods of contraception. To request this film contact the Canadian Film Institute, 303 Richmond, Rd., Ottawa, Ontario.

Obstetrics

Becoming

In Super 8mm, 30 min. long, this describes the Lamaze method of natural childbirth. It deals with the physical and psychological factors of nonmedicated birth, and stresses the roles played by physician, nurse, and husband in creating and sustaining confidence within the family.

The film is designed for nursing education and inservice training, childbirth educational classes, and classes dealing with family dynamics and human relationships. It may be purchased from: Hospital Audio Visual Education, 606 Halstead Ave., Mamoroneck, N.Y., 19543, U.S.A.

Hello World

This is a 35-minute, 16mm film designed to answer the questions that prospective mothers and fathers have about the birth of their child. The film was made by the Ottawa-Carleton Regional Health Unit in cooperation with the University of Ottawa and the Ottawa General Hospital's Obstetrics and Gynecology Department. The film is available from the Ottawa-Carleton Regional Health Unit, 1827 Woodward Drive, Ottawa, Ontario, K2C 0R5.

Pamphlets

Easy Eating with Canada's Food Guide

This is a nutrition publication containing suggestions on what to eat for weight control, convenience, snacks, and how to cut food costs. The pamphlet is available in quantity from: Communications Branch, Ontario Ministry of Health, Hepburn Block, Toronto, Ontario, M7A 1S2.

Catalogues

Films on the Health Sciences is a recent catalogue of films researched and edited by Margaret Britt. Included in the catalogue are films in the following areas: addictions, adolescent development, adoption, anatomy, child care and development, dental health, diseases, first aid and safety, hospitals, marriage and family life, mental health, nursing and patient care, and mental illness. For your copy of the Films on the Health Sciences Catalogue, write to the Information Officer, Canadian Film Institute, 303 Richmond Road, Ottawa.

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Publications recently received in the Canadian Nurses' Association Library are available *on loan* — with the exception of items marked **R** — to CNA members, schools of nursing, and other institutions. Items marked **R** include reference and archive material that does *not* go out on loan. Theses, also **R**, are on Reserve and go out on Interlibrary Loan only.

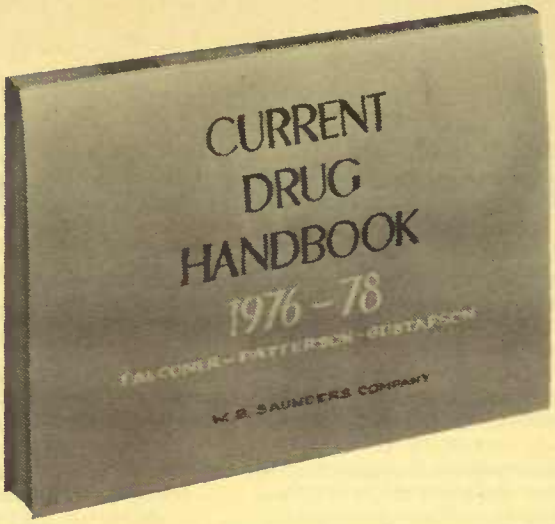
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● increase the variety of your work and gain experience to help you specialize?	Work in a hospital, a nursing home or a doctor's office. Enjoy assignments in a private residence, hotel or summer camp. Perhaps you want specialized experience in CC., IC or another field. Medox can give you more variety.
● work for a company that takes special care of its nurses in every way, including pay?	Medox employs the best people at the best rates of pay in the temporary nursing field. You owe it to yourself to contact Medox.
● free yourself from too many mandatory shifts and shift rotation?	Medox nurses get the best of both worlds: the assignments they want and the shift work they prefer. Because there are more assignments available.
● to take advantage of free-lance nursing without the paperwork?	When you work with Medox, we look after all paperwork. We pay you weekly and make normal deductions. Medox is your employer: the times, shifts and assignments are yours to choose.
● trade the rigid schedules of full-time nursing for the flexibility of temporary or part-time work?	As a Medox nurse, you can ease off the strict schedules of full-time nursing. Cut down to a few shifts or split shifts a week: the choice is yours.
● choose to work only one or two days a week?	As a Medox nurse, you can pick the days you want to work: you're automatically on call for the time you want. Medox nurses have more time to themselves, they can arrange as many "free" days as they want.
● work shifts that tie in with your husband's work schedule?	Wouldn't it be nice to work the same shifts as your husband; both home together and both earning good incomes? If his shifts change, Medox will arrange to change yours too.
● retire from nursing, but not completely?	If the idea of retirement appeals to you, yet not the thought of forced inactively, becomes a Medox nurse. Be retired on the days you want.



"As a registered nurse with more years experience behind me than I care to think about, I know how important it is to keep growing in your job—to avoid that awful feeling of being stuck in the same rut. Certainly what you're doing is tremendously worth-while, and heaven knows there is a desparate shortage of nurses. But your job must be worthwhile *to you*, or else you'll eventually want to drop out".

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"As far as you're concerned, however, the key phrase is "Temporary Assignments". Because, as you can see by the chart above, you can choose just about any working condition, or shift, or professional discipline you want". "It comes down to this: if you want more from nursing than you're getting now, talk to Medox".

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The Canadian Nurses' Association does not review the personnel policies of the hospitals and agencies advertising in the Journal. For authentic information, prospective applicants should apply to the Registered Nurses' Association of the Province in which they are interested in working.

Address correspondence to:

The Canadian Nurse
50 The Driveway
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Classified Advertisements

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Registered Nurses required for 70-bed accredited active treatment Hospital. Full time and summer relief. All AARN personnel policies. Apply in writing to the: Director of Nursing, Drumheller General Hospital, Drumheller, Alberta.

British Columbia

Experienced General Duty Nurses required for small hospital, North Vancouver Island area. Salary and personnel policies as per RNABC contract. Residence accommodation $30.00 per month. Transportation paid from Vancouver. Apply to: Director of Nursing, St. George's Hospital, Box 223, Alert Bay, British Columbia, V0N 1A0.

Experienced Nurses (eligible for B.C. registration) required for 409-bed acute care, teaching hospital located in Fraser Valley, 20 minutes by freeway from Vancouver, and within easy access of varied recreational facilities. Excellent Orientation and Continuing Education programmes. Salary $1,049.00 to $1,239.00. Clinical areas include: Medicine, General and Specialized Surgery, Obstetrics, Pediatrics, Coronary Care, Hemodialysis Rehabilitation, Operating Room, Intensive Care, Emergency. **Practical Nurses** (eligible for B.C. License) also required. Apply to: Administrative Assistant, Nursing Personnel, Royal Columbian Hospital, New Westminster, British Columbia, V3L 3W7.

General Duty Nurses for modern 41-bed hospital located on the Alaska Highway. Salary and personnel policies in accordance with RNABC. Accommodation available in residence. Apply: Director of Nursing, Fort Nelson General Hospital, Fort Nelson, British Columbia.

General Duty Nurses for modern 35-bed hospital located in southern B.C.'s Boundary Area with excellent recreation facilities. Salary and personnel policies in accordance with RNABC. Comfortable Nurse's home. Apply: Director of Nursing, Boundary Hospital Grand Forks, British Columbia, V0H 1H0.

Nova Scotia

Faculty Positions — Positions available for all clinical nursing areas in an integrated four-year baccalaureate program, offered in cooperation with Dalhousie University School of Nursing. Master's degree in clinical speciality areas, and/or curriculum development, education required. Positions involve responsibility for theory and clinical teaching in local hospitals. Candidates should be available July 1, 1976. Applications, with curricula vitae, should be directed to: Dr. Walter Shelton, Academic Dean, Mount Saint Vincent University, Halifax, Nova Scotia, B3M 2J6, Canada.

Ontario

Registered Nurses for 34-bed General Hospital. Salary $945.00 to $1,145.00 per month, plus experience allowance. Excellent personnel policies. Apply to: Director of Nursing, Englehart & District Hospital Inc., Englehart, Ontario, P0J 1H0.

Registered Nurses and Registered Nursing Assistants for 45-bed Hospital. Salary ranges include generous experience allowances. R.N.'s salary $1,045. to $1,245. and R.N.A.'s salary $735. to $810. Nurses residence — private rooms with bath — $60. per month. Apply to: The Director of Nursing, Geraldton District Hospital Geraldton, Ontario, P0T 1M0.

Registered Nurses required for our ultramodern accredited 79-bed General Hospital in bilingual community of Northern Ontario. French language an asset, but not compulsory. Salary is $1,115. to $1,315. monthly with allowance for past experience and 4 weeks vacation after 1 year. Hospital pays 100% of O.H.I.P., Life Insurance (10,000). Salary Insurance (75% of wages to the age of 65 with U.I.C. carveout), a 35c drug plan and a dental care plan. Master rotation in effect. Furnished bachelor apartments available nearby and reserved through the Personnel Department. Excellent personnel policies. Apply to: Personnel Director, Notre-Dame Hospital, P. O. Box 8000, Hearst, Ontario, P0L 1N0.

Quebec

Nurses for Children's Summer Camps in Quebec. Our member camps are located in the Laurentian Mountains and Eastern Townships, within 100 mile radius of Montreal. All camps are accredited members of the Quebec Camping Association. Apply to: Quebec Camping Association, 2233 Belgrave Avenue, Montreal, Quebec, H4A 2L9, or phone 489-1541.

Quebec

Registered Nurses and Nurses Aides wanted for summer camps end of June to end of August. Must be qualified to work in Quebec. Will consider one month or two month basis. Apply: Jewish Community Camps, 5151 Cote Ste. Catherine Road, Montreal, Quebec, H3W 1M6. Telephone: (514) 735-3669.

One Registered Nurse for Children's Co-Ed Camp. End of June to August 20th. Prefer season. $700 plus travel. Laurentian Region. Doctor on staff, excellent facilities. Write: Joseph A. Friedman, Director, YM-YWHA & NHS of Montreal, 5500 Westbury Avenue, Montreal H3W 2W8, Quebec.

Saskatchewan

Director of Nursing required for active rural hospital in Southern Saskatchewan. Duties to commence immediately. Salary according to schedule and experience. For further information please contact: Clifford Day, Chairman, or G.P. Williamson, Secretary-Treasurer, Kincaid Union Hospital, Kincaid, Saskatchewan.

Director of Nursing: Immediate applications are invited for the position of Director of Nursing in the 43-bed Wadena Union Hospital. Fringe benefits include Registered Pension Plan, Group Life Insurance and Income Replacement Plan. This is a seven year old well-equipped hospital in a town of 1500 population serving a large rural population. Wadena is centrally located 130 miles from each of two major Saskatchewan centres. Supervisory experience is essential, Nursing Administration course desirable. Attractive salary scale in effect. Apply stating qualifications and experience to: Administrator, Wadena Union Hospital, P.O. Box 10, Wadena, Saskatchewan, S0A 4J0.

Registered Nurses are required immediately for the 43-bed Wadena Union Hospital. This is a modern, attractive acute care hospital situated in the town of Wadena, Saskatchewan, a friendly parkland community with a population of 1500. Attractive salary and fringe benefits are provided under the Saskatchewan Union of Nurses agreement in effect. Please direct applications to: Administrator, Wadena Union Hospital, P.O. Box 10, Wadena, Saskatchewan.

United States

Landed Immigrant Nurses — If you are looking for an exciting change then contact us. We are offering **SRNs** the opportunity to work in the U.S.A. for six months or longer. Choice locations available. We will pay your fare and arrange accommodations for you. Free Health Insurance and Visa Sponsorship. Write: First Girl International, 333 North Michigan Avenue, Chicago, Illinois, 60601.

R.N.'s — Iowa Methodist Medical Center invites you to explore nursing opportunities in orthopedics, rehabilitation, ICU and CCU, medical-surgical and pediatrics. 700-bed general teaching hospital with expansion plan. Well organized and directed nursing program with in depth orientation and inservice program. Excellent personnel and benefit program. Competitive salary and promotional opportunity. Will assist with visa for immigration. If interested in further details please contact: Personnel Director, Iowa Methodist Medical Center, 1200 Pleasant Street, Des Moines, Iowa, 50308 or phone (515) 283-6313.

Texas wants you! If you are an **RN**, experienced or a recent graduate, come to Corpus Christi. Sparkling City by the Sea . . . a city building for a better future, where your opportunities for recreation and studies are limitless. Memorial Medical Center, 500-bed, general, teaching hospital encourages career advancement and provides in-service orientation. Salary from $785.20 to $1,052.13 per month, commensurate with education and experience. Differential for evening shifts, available. Benefits include holidays, sick leave, vacations, paid hospitalization, health, life insurance, pension program. Become a vital part of a modern, up-to-date hospital, write or call: John W. Gover, Jr., Director of Personnel, Memorial Medical Center, P.O. Box 5280, Corpus Christi, Texas, 78405.

R.N.'s needed immediately for a 31-bed acute care hospital. Rotating shifts. We will assist in making arrangements to come to beautiful Wyoming. Call Collect: Director of Nurses, Cheryl Karkheck — 307-682-8811.

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Nursing Office Supervisor

As a member of nursing administration this individual will have the responsiblity for the management and assignment of part time and casual staff, and have an interest in assuming more senior responsibilities.

Preference is given to Baccalaureate degree or equivalent and must be eligible for Saskatchewan registration. Several years experience in nursing service indicating progressive responsibility including Head Nurse level is necessary.

The position is available April 15, 1976.

Salary is commensurate with preparation and experience.

Apply to:

Director of Personnel
University Hospital
Saskatoon, Saskatchewan
S7N 0W8

Okanagan College Position Vacancy **Nursing Faculty**

Okanagan College is implementing a Diploma-level Nursing Program in September 1976. Applications are invited for instructional positions. Two appointments will be made in the Spring of 1976. A third appointment will be made toward the end of the year.

Duties
Classroom and clinical instruction; curriculum development; other duties as assigned by the Coordinator of Nursing Education. Instructors will be required to travel to nearby communities.

Qualifications
Master's Degree preferred; Bachelor's minimum. Teaching experience desirable; at least two years' clinical experience essential.

Other instructional positions may be available in the Spring of 1977.

Salary and working conditions in accordance with the Academic Faculty Agreement.

Applications to be submitted to:

The Principal
Okanagan College
1000 KLO Road
Kelowna, B.C.
V1Y 4X8

Closing date: March 15, 1976.



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Our patient population consists of the baby of less than an hour old to the adolescent who has just turned seventeen. We see them in Intensive Care, in one of the Medical or Surgical General Wards, or in some of the Pediatric Specialty areas.

They abound in our clinics and their numbers increase daily in our Emergency.

If you do not like working with children and with their families, you would not like it here.

If you do like children and their families, we would like you on our staff.

Interested qualified applicants should apply to the:

Director of Nursing
Montreal Children's Hospital
2300 Tupper Street
Montreal 108, Quebec

SOFRA-TULLE® Roussel
Framycetin Sulphate B.P. Antibiotic

Indications: Treatment of infected or potentially infected burns, crush injuries, lacerations. Also varicose ulcers, bedsores and ulcerated wounds.

Contraindications: Known allergy to lanolin or framycetin. Cross-sensitization may occur among the group of streptomyces-derived antibiotics (neomycin, paromomycin, kanamycin) of which framycetin is a member, but this is not invariable.

Precautions: In most cases absorption of the antibiotic is so slight that it can be discounted. Where very large body areas are involved (e.g. 30% or more body burn), the possibility of ototoxicity being eventually produced should be considered. Prolonged use of antibiotics may result in the overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Dosage: A single layer to be applied directly to the wound and covered with an appropriate dressing. If exudative, dressings should be changed at least daily. In case of leg ulcers cut dressing accurately to size of ulcer and when infected stage has cleared, replace by non-impregnated dressing.

Supplied: A lightweight, paraffin gauze dressing impregnated with 1% framycetin sulphate B.P. Sofra-Tulle also contains anhydrous lanolin 9.95%. Available in 2 sizes: 10 cm by 10 cm sterile single units, cartons of 10 and 50; 10 cm by 30 cm sterile single units, cartons of 10. Store at controlled room temperature.

Registered Nurses

Your community needs the benefit of your skills and experience. Volunteer now to teach Patient Care in The Home and Child Care in The Home Courses.

contact your local St. John Ambulance

School of Nursing

Assistant Director
required in a 2 year English language diploma Nursing program

Qualifications
Master's degree in Nursing Education, preferred, with experience in Nursing Education.

Administration and teaching and at least one year in a Nursing Service position.

Eligible for registration in New Brunswick.

Apply to:

Harriett Hayes
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The Miss A.J. MacMaster School of Nursing
Postal Station A, Box 2636
Moncton, N.B.
E1C 8H7

General Duty Nurses

Required immediately for acute care general hospital expanding to 343 beds plus proposed 75 bed extended care unit.

Clinical areas include: medicine, surgery, obstetrics, paediatrics, psychiatry, activation & rehabilitation, operating room, emergency and intensive and coronary care unit.

Must be eligible for B.C. Registration.

Personnel policies in accordance with R.N.A.B.C. Contract:

Salary: $850 — $1020 per month (1974 rates)

Shift differential

Apply to:
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Prince George Regional Hospital
Prince George, B.C.

The George Brown College Nursing Division in Toronto

is offering a 19-week program in Critical Care Nursing for registered nurses, starting March 8, 1976. Theory and clinical experience are combined for optimum learning experience. The program, which runs twice a year, is taught at the College's St. Michael's Hospital Campus, 27 Queen Street East.

For more information call (416) 967-1212 ext. 269.

Assistant Director of Nursing

Assistant Director of Nursing required for an accredited 130-bed General Hospital with a major expansion project underway.

The city of Grande Prairie is located 285 miles northwest of Edmonton and is well serviced by bus and air.

Preference will be given to applicant with practical experience at the senior administration level combined with baccalaureate degree and/or other formal education in the field of administration.

Salary commensurate with education and experience.

Position available by May 1st 1976.

Please apply to:
Director of Nursing
Grande Prairie General Hospital
Grand Prairie, Alberta
T8V 2E8

Registered Nurses and Nurses Assistants

required for 110-bed hospital for chest diseases situated in the Laurentians, 55 miles north of Montreal.

Salaries are now being updated.

Excellent fringe benefits.

Quebec language requirements do not apply for Canadian applicants if registered in Quebec before July 1976.

Apply:
Director of Nursing
Mount Sinai Hospital
P.O. Box 1000
Ste-Agathe des Monts, Quebec
J8C 3A4

University of Victoria School of Nursing

New School of Nursing requires **4 faculty members** with at least Master's level preparation and successful experience in rehabilitation/gerontology/group work/problem solving/community health to implement a 2 year integrated B.S.N. curriculum for R.N.'s.

This program seeks to enhance the current skills of R.N.'s by expanding psychosocial awareness and developing skill in use of the scientific method as related to nursing.

"Generalist" is focused, clinical practice will be primarily in extended care and rehabilitation units; some clinical work arranged on the bases of students' experiences and career goals. Interdisciplinary studies and innovative learning experiences for highly motivated academically able students require close faculty coordination and co-operation, and provides an unusual opportunity for creativity. Salary and rank based on education and experience.

Application and curriculum vitae before March 1 to:
Dr. Isabel MacRae, Director
School of Nursing
University of Victoria
P.O. Box 1700
Victoria, British Columbia
V8W 2Y2

Director of Nursing

Career opportunity to assist in administration and planning of patient care in progressive 348 bed hospital. The position will present a challenge for a person with a desire to achieve and maintain the highest standard of excellence within the Nursing Department.

Candidate should have a minimum of a B.Sc.N. Degree as well as progressive experience in Nursing Administration.

Salary commensurate with experience. Full range of benefits and excellent working conditions.

Apply in confidence to:
Director of Personnel
Public General Hospital
106 Emma St.
Chatham, Ontario
N7L 1A8

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Stratford, Ontario
N5A 2Y6
(Area Code 519, 271-2120, Extn. 217)

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Fully accredited — 220 beds

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The Obstetrical facilities are presently being expanded and renovated to provide a modern Labour and Delivery area, new Nursery facilities and a new Post Partum Suite providing for 1,500 deliveries annually.

Pleasant University City of 65,000. One hour from Toronto.

Apply to:
Personnel Department
Guelph General Hospital
115 Delhi Street
Guelph, Ontario
N1E 4J4
Telephone: (519) 822-5350 Ex.: 203

Foothills Hospital, Calgary, Alberta

Advanced Neurological-Neurosurgical Nursing for Graduate Nurses

A five month clinical and academic program offered by The Department of Nursing Service and The Division of Neurosurgery (Department of Surgery)

Beginning: March, September

Limited to 8 participants
Applications now being accepted

For further information, please write to:
Co-ordinator of In-service Education
Foothills Hospital
1403 29 St. N.W. Calgary, Alberta
T2N 2T9

North Newfoundland & Labrador
requires

Registered Nurses Public Health Nurses

International Grenfell Association provides medical services for Northern Newfoundland and Labrador. We staff four hospitals, eleven nursing stations, eleven Public Health units. Our main 180-bed accredited hospital is situated at St. Anthony, Newfoundland. Active treatment is carried on in Surgery, Medicine, Paediatrics, Obstetrics, Psychiatry. Also, Intensive Care Unit. Orientation and In-Service programs. 40-hour week, rotating shifts. Living accommodations supplied at low cost. **Public health** has challenge of large remote areas. Excellent personnel benefits include liberal vacation and sick leave. Union approved salaries start at $810.00.

Apply to:
International Grenfell Association
Assistant Administrator of Nursing Services
St. Anthony, Newfoundland
A0K 4S0

Conestoga College of Applied Arts and Technology

The College invites applications for Faculty positions in our various Nursing Division which are located in Cambridge, Guelph, Kitchener-Waterloo, and Stratford. We have immediate openings. Candidates must have suitable qualifications and at least two years nursing experience. Salary will be commensurate with background and experience. This position is open to both women and men.

Applications, in writing, should be forwarded to:
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Conestoga College of Applied Arts and Technology
299 Doon Valley Drive
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Queen Elizabeth Hospital of Montreal Centre

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Registered Nurses and Registered Nursing Assistants

Quebec language requirements do not apply to Canadian applicants.

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Queen Elizabeth Hospital of Montreal Centre
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2100 Marlowe Ave., Montreal, Quebec
H4A 3L6







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Medical Services, Northwest Territories Region, is offering term and permanent positions for qualified, experienced nurses in Canada's North.

Openings will be available from May to September at nursing stations and hospitals throughout the Arctic.

If you would like the challenge of living and working in one of our last great frontiers, then fill out and mail the attached coupon.

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Registered Nurses and Nursing Assistants for all units
Clinical specialists for Operating Room, Intensive Care, Patient Care and Education.

Director of Nursing

The Hospital

A Director of Nursing Services is required for a new 100 bed extended care hospital, presently under construction, and planned for opening in November of 1976.

The Position

Responsibilities include planning, organizing, staffing, coordinating and fully directing all aspects of the nursing services. The Director will be a member of the senior management team concerned with the total operation of the hospital.

Qualifications

Qualifications required are several years experience at a senior supervisory level, or as an assistant Director, or Director of Nursing in a hospital setting, preferably a baccalaureate in nursing, and eligibility to register with the Provincial professional nursing organization.

Salary

This position offers excellent working conditions including the challenge of opening an entirely new facility and working with other senior staff in the development of all patient care programs for the hospital. The salary is open to negotiation within R.N.A.B.C. pay scales and will be commensurate with qualifications and experience. The successful applicant must be prepared to assume the duties of this position effective September 1, 1976.

Interested applicants should send their application and resume to:

The Administrator
Overlander Extended Care Hospital
890 McGillvray Street
Kamloops, B. C.

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- **Modern 700 bed non-sectarian hospital**
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Director, Nursing Service
Jewish General Hospital
3755 cote ste. Catherine Road
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H3T 1E2

Extension Course in Nursing Unit Administration

Applications are invited for the extension course in Nursing Unit Administration, a program to help the head nurse, supervisor or director of nursing up-date his or her management skills. Candidates will be registered nurses or registered psychiatric nurses employed in management positions on a full-time basis.

The program provides a seven month period of home study with two five day intramural sessions, one preceding and one following the home study. For the 1976-77 class the initial intramural sessions will be held regionally as follows:

Vancouver August 23—27
Hamilton September 13—17
Toronto September 20—24
Montreal (French) August 30 — September 3
Halifax August 30 — September 3
Winnipeg September 13—17
Ottawa September 20-24

Early application is advised. Applications will be accepted until **May 15, 1976,** if places are still available at that time. After acceptance, the tuition fee of $250.00 is payable on or before July 1, 1976.

The program is co-sponsored by the Canadian Nurses Association and the Canadian Hospital Association and is available in French or in English.

For additional information and application forms write to:

Director,
Extension Course in Nursing Unit Administration,
25 Imperial Street,
Toronto, Ontario,
M5P 1C1.

657 bed, accredited, modern, well equipped General Hospital, rapidly expanding...



Saint John General Hospital

Saint John, N.B., CANADA

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General Staff Nurses & Registered Nursing Assistants

In all general areas: Medical, Surgical, Pediatrics, Obstetrics, Chronic and Convalescent, several Intensive Care areas and Psychiatry.

- Active, progressive in-service education program. Special Attention to Orientation.

Allowance for Experience and Post Basic Preparation

FOR FURTHUR INFORMATION APPLY TO
PERSONNEL DIRECTOR
Saint John General Hospital
P.O. BOX 2000 Saint John, New Brunswick E2L 4L2

Community Mental Health Nurse

Opportunity for innovative *Nursing practice* in a Centre located in semi-rural Nova Scotia near Acadia University in Wolfville. Unique opportunity to work cooperatively with a multidisciplinary group including psychiatrists, social workers, and psychologists. Participation in active clinical programmes including individual, group, marital and family therapy. In addition, duties are to include liaison and consultative services to public health nurses, general hospital staffs etc. regarding mental health programming.

Qualifications: At least 2 years experience in psychiatric or mental health nursing. Current registration as a registered nurse in the Province of Nova Scotia. Master's degree in psychiatric nursing preferred. Baccalaureate degree in nursing with additional educational preparation in psychiatric or mental health nursing or equivalent acceptable.

Apply stating qualifications and working resume to:

John W. Murphy, M.S.W.
Executive Director
Fundy Mental Health Centre
Wolfville, Nova Scotia

Shaughnessy Hospital
Director of Patient Services

The establishment of a new management structure for Shaughnessy Hospital, appropriate to its role as a member hospital within the British Columbia Medical Centre complex, requires a senior patient care executive capable of full participation in its development. Shaughnessy Hospital is a large well-established facility providing acute, intermediate and extended care services presently under development as a major teaching referral centre.

Candidates should possess basic nursing qualifications with post-graduate education in health or nursing administration and a demonstrated record of innovative leadership, preferably in a teaching hospital setting. Essential is the ability to plan for and implement anticipated changes in patient care concepts.

Please submit applications in confidence to:

Chairman, Selection Committee
Director of Patient Care
Shaughnessy Hospital
4500 Oak Street
Vancouver, B.C. V6H 3N1



General Staff Nurses

required for

Regina General Hospital

openings in all departments

Recognition Given For Experience
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Apply:

Personnel Department
Regina General Hospital
Regina, Saskatchewan
S4P 0W5

Dean
University of Maine School of Nursing

The University of Maine School of Nursing is accepting applications for the position of the Dean of the School of Nursing located in Portland, Maine. The Dean, as chief administrative and academic officer of the School, charged with directing the instructional programs and executing the educational objectives of the School, is responsible to the President of the University of Maine at Portland-Gorham. The School currently has an enrollment of 400 undergraduates, an active Bureau of Continuing Education for Nursing, and participates in a consortium for graduate level education for Nursing. Requirements include: Graduation from NLN accredited program in professional nursing, and an earned doctoral degree. Clinical practice in Nursing and experience teaching in a baccalaureate nursing program are required, as are demonstrated administrative capabilities.

Rank and salary commensurate with experience.
Position available July 1, 1976.

Submit credentials by March 15, 1976 to:

Jacqueline Karabin
Chairman, Dean Search Committee
University of Maine at Portland-Gorham
96 Falmouth Street
Portland, Maine 04103

We are an equal opportunity employer

Faculty Positions

1 Professor or Associate Professor of Nursing to coordinate the Master's Program in association with the Director of the School. It is expected that the candidate would have completed a doctorate, and have had clinical, nursing education and research experience. The appointment includes teaching in the graduate and undergraduate programs, and provides opportunity for research.

2 Because a number of our faculty will be leaving to pursue further education at the end of this academic year, there will be positions available for qualified faculty. We are especially interested in candidates with preparation in mental health and psychiatric nursing, and in community health nursing.

Interesting developments for the future make Dalhousie School of Nursing a challenging place in which to contribute to nursing education and to further one's own professional goals.

- new and modern quarters for the School are planned
- our masters program is now in its first year
- some research projects are getting underway and Dr. Margaret Scott Wright from Edinburgh, well known in Canada and internationally, will be our new Director.

Applications, with curriculum vitae, should be sent to Muriel E. Small, Director, School of Nursing, Dalhousie University, Halifax, Nova Scotia.

City of Vancouver

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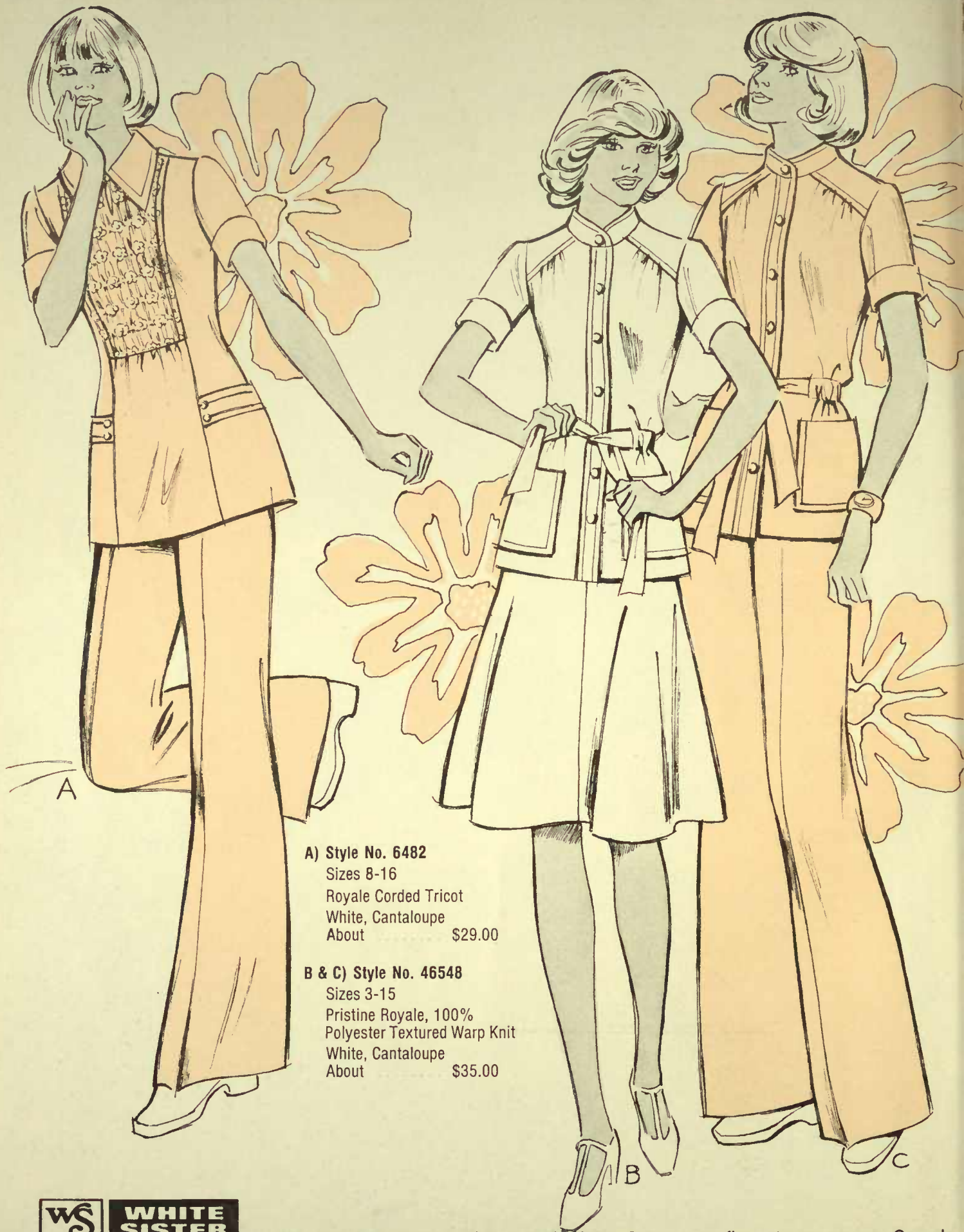
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The Canadian Nurse

The official journal of the Canadian Nurses' Association published monthly in French and English editions.

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New approaches to childbirth and the care of the newborn give nurses the opportunity to take an active role in promoting a healthy mother and child. That's why the focus, this month, is on that very important character, the neonate. The photo of the one on the cover was provided by Information Canada, Ottawa.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses' Association.

ISSN 0008-4581

Indexed in International Nursing Index, Cumulative Index to Nursing Literature, Abstracts of Hospital Management Studies, Hospital Literature Index, Hospital Abstracts, Index Medicus. *The Canadian Nurse* is available in microform from Xerox University Microfilms, Ann Arbor, Michigan, 48106.

The Canadian Nurse welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-space. Send original and carbon. All articles must be submitted for the exclusive use of *The Canadian Nurse*. A biographical statement and return address should accompany all manuscripts.

Subscription Rates: Canada: one year, $8.00; two years, $15.00. Foreign: one year, $9.00; two years, $17.00. Single copies: $1.00 each. Make cheques or money orders payable to the Canadian Nurses' Association.

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Perspective

'What's the use of a new invention," someone is supposed to have asked Benjamin Franklin. To which he replied:"What's the use of a newborn child?"

Well, useful or not, the neonate is an important, often noisy, part of the responsibilities assumed by many nurses. His well-being, and that of his mother during those first few , crucial, postpartum days, depends, in large measure, on the level of nursing care they both receive.

To a great extent, too, it is the nurse who determines the quality of the relationship that mother is going to have with her new offspring when she returns home. If, during her stay in hospital, she has grown familiar with the pattern of her baby's needs and desires and has learned how to cope with them, she is less likely to look on those early weeks and months of co-existence as a frightening period of never ending new responsibilities that she can't possibly handle. One of the ways a nurse can help get this relationship off to a good start, is by helping the mother to establish a successful breast-feeding routine —*if* that is the ambition of the mother. That's why, this month we offer three articles dealing with this topic.

Fashions come and go and right now, breast-feeding seems to be enjoying a resurgence of popularity. Our prime minister's wife has set an example for other young mothers by nursing all three of her children. She refuses to let official duties stand in the way of this responsibility and, as a result, the three youngest Trudeau's are already experienced world travelers.

Not every mother is going to choose to breast-feed her baby, but most mothers are concerned about a more natural approach to the entire process of gestation, childbirth and child care. That's why the story by Montreal artist and writer, Beverly MacLellan, is included in this issue. Somehow, the support and encouragement that she needed to back up her preparation and training in childbirth and infant care were not available when she needed them most.

"Putting it all together," in the case room, the nursery and obstetrics ward, so that the neonate gets off to a good start and his mother remembers the event of his birth and her stay in hospital as an enriching experience, takes real skill and teamwork. And that's what nursing is all about, isn't it? "What's the use of a newborn child? To raise the dead heart — To set wild the fettered hope." (Witter Bryner)

— M.A.H.

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Herein



Bernadet Ratsoy was the driving force behind the setting up, in 1971, of a new postpartum program at St. Paul's Hospital in Vancouver. The program, aimed at encouraging parents to make decisions and adopt a positive, independent role in the care of their newborn babies, is described in *The Canadian Nurse,* April 1974.

In this month's issue, she relates her experience at St. Paul's to the broader field of health care planning and outlines a strategy that any nurse can use to launch her own ideas.

The article is based on a paper prepared for the 63rd anniversary meeting of the RNABC when members examined the potential role of the nurse in health care planning.

Next month, Barbara Geyer a nurse at the Charles Camsell Hospital in Edmonton, describes the nursing care involved in the replantation of a severed limb in a young patient.

Two-year old Theresa was brought to the hospital with her left arm completely severed. Today, she has close to normal function in that limb.

Input

Nightingale debunked

As a student of Florence Nightingale for 25 years, I wish to take exception to the image projected by Simpson and Green in the December issue of *The Canadian Nurse*. Florence Nightingale is what is *wrong* with the nursing profession.

She most certainly had organizing ability but did not personally assemble a staff in less than a week. She spent most of the time in her rooms in Pall Mall while four friends interviewed the applicants who were few in number.

It would have been impossible for anyone to impose order in Scutari, even Florence Nightingale. Efficient it never became!

Florence Nightingale warm and sympathetic? Never! She was a cold fish, her personal relationships were unsatisfactory and she remained emotionally immature throughout her life.

She spent less than three of her 90 years practising nursing and never set foot in a hospital, except as a visitor, after 1856. Founded a school of nursing reluctantly and visited it for the first time, 22 years later. Opposed the registration of nurses and the enfranchisement of women. Despised women. Liked men. Was a martyr, fanatic, mystic and hypochondriac.

Her influence has done more harm to the nursing profession than any other single factor. Florence Nightingale was not the founder of nursing, but because her "clout" was greater than anyone else's, her attitudes prevailed, giving rise to the apprentice system and a militaristic structure with a chain of command, hierarchical form and unquestioning obedience.

She has descended through the last 120 years as a myth. Sweet, gentle, perfect, noble, self-sacrificing lady. Florence Nightingale is the epitome of the perfect nurse. Ergo, every nurse must be sweet, gentle, perfect, noble, self-sacrificing and a lady.

The nursing profession has been led by pale imitations of the myth of Florence Nightingale since 1885 or thereabouts, ladies every one of them."Ladies"nursing did not need,but tough, assertive women.

Because of the legend of Florence Nightingale, there is no room in the nursing profession for the iconoclast, the intellectual, the rebel or the maverick. Every nurse has to fit the mold, drab, dull, conditioned and brainwashed. Yet, in every field of human activity, progress and innovation has been brought about by individuals or groups who have been rebels, iconoclasts, intellectuals or mavericks.

Name five statesmen whose names are in the public domain. Name five writers. Name five politicians known throughout the English speaking world. Name five nurses.

Well, there is Florence Nightingale. And Florence Nightingale. And Florence Nightingale. And Florence Nightingale. Maybe, Edith Cavell because she got shot. Who else?

— Pat Barr, Carstairs, Alta.

Heart of the matter

I am writing to comment on what has to be the best article ever published in *The Canadian Nurse* — Colleen McElroy's "Caring for the Untreated Infant" (December 1975). The author sees clearly through the maze of confusion that is the downfall of so many of us — rigid, blanket policies, legal red tape, satisfaction of curiosity (as opposed to legitimate research) — to the heart of the matter, *this one patient's welfare and best interests.*

A humanist philosophy is the only one that has any place in the care of the untreatable patient; with it, one can always be sure of doing the right thing. That will mean to treat one patient, not treat another, or change approaches with a third, without hesitation.

We have generally applied "rules" of care for the living, with intensity of application measured appropriately to each situation. Why are we so afraid to develop appropriate care for the dying?

Appropriate care would mean the positive promoting of comfort measures, as actively as is necessary for the patient's comfort, rather than just negatively withholding life support. Care of the dying (or untreatable) still means caring, and as such resolves concern over questions of feeding such a patient, or providing stress-relieving oxygen therapy, thereby "prolonging his suffering."

McElroy touches a crucial point when she mentions these patients have no awareness of time; rather the problem is one of our projecting our own feelings and fears onto them.

This is definitely an area that cries out for further discussion and debate. Any institution that cares for the ill would do well to organize a workshop or study session to face the question.

— Lucille Pakalnis, R.N., Sudbury, Ontario.

Cutting corners

Being a graduate of the 2-year program and having worked three years in a hospital setting, I have a poor regard for this course. At the present time in Ontario, especially since budget cuts have reduced the staff drastically, new graduates are placed alone on wards on afternoons and nights and are often in charge. They are usually young (18 and 19) and many of them have little practical experience. I feel this is placing extreme pressure on young grads and also placing the life of the patient in jeopardy.

Recently I have come across young grads who 1) gave I,000 ml of IV with pitocin in it in a very short time and didn't know of the dangers of this,2) one new grad who catheterized a postpartum patient for 1100 ml straight and had no concept of the fact this procedure could set a patient into shock as the bladder collapses, 3) another grad was to give a preop enema. The ward was very busy and she had never performed this procedure. No one was available to assist her.

I realize these are only three instances of poorly prepared grads but I must state the patients in the care of these girls were clearly not in the safest hands.

Another very serious problem is the system of admissions to community colleges. The quality of applicants is not well assessed and often colleges are more concerned with filling their enrolment quotas than pruning the group and having those suited to nursing placed in the program. It seems to me we have lowered our standards now that hospitals are no longer competing for the best students.

— Margaret, Davidson, Chatham, Ontario.

Psychiatric Journals

As the national nursing library we try to achieve complete runs of Canadian nursing journals. At the moment we are trying to find back issues of the *Canadian Journal of Psychiatric Nursing* to complete our holdings, and to fill an outside request. The issues we seek are volumes 1 to 7, number 7 inclusive, that is from 1960 to August 1966. If any readers can assist us, we shall be most grateful.

— M. Parkin, Librarian, CNA House, 50 The Driveway, Ottawa.

Pension Benefits Amended

The December 1975 issue of The Canadian Nurse contained an article "Is There Sex Discrimination in Health Care?", which stated that Ontario Community Colleges discriminate against female employees for pension purposes. This is not the case, and has not been so since November 1974. In that amendment, the word "Spouse" was submitted to include either the widow or the widower of an employee. There is no longer any need for a widower's previous dependence on a female employee to entitle him to the pension death benefit.

I trust that this will clear up any misunderstanding of our pension plan that you may have received. As you know, all colleges are under the same plan.

— E. Karen Sendall, Employment and Benefits Officer, Conestoga College of Applied Arts and Technology, Kitchener, Ontario.

The editor replies: Thank you for pointing out this inadvertent error on our part. The example of perceived discrimination you refer to was cited by a teacher in a community college. It was incorporated in the article in good faith since it was impossible to verify all of the comments contained in the many questionnaires returned by readers. Perhaps this error on our part will serve some purpose if it alerts other faculty members to the amendment you refer to. The Canadian Nurse *apologizes for any inconvenience you may have suffered.*



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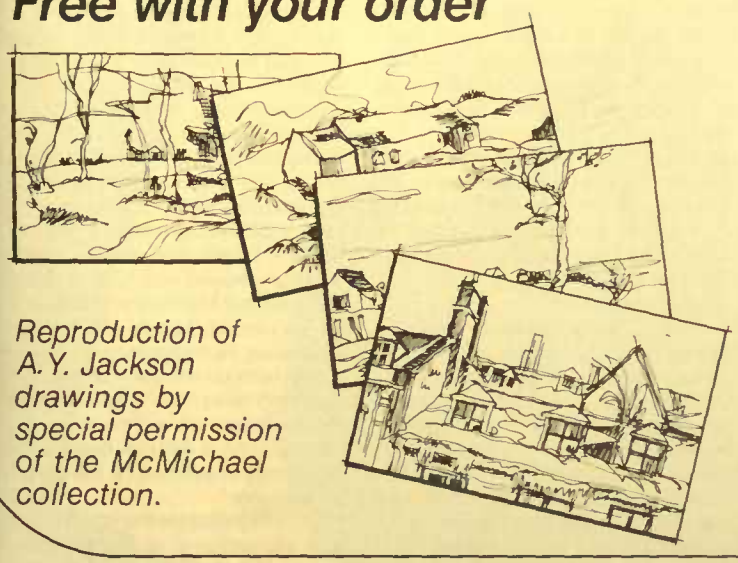
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News



NBARN members Arlyn McGee (far left) and Evelyn Matthieu (center) meet Dr. William Forster, N.B. Director of Mental Health Services during a recent workshop on crisis intervention. Resource persons were Patricia Delbridge (far right) and Dorothy Burwell.

New Brunswick nurses with a special interest in providing more effective care and better understanding of the suicidal patient received some expert assistance recently at a two-day workshop on "Suicide and Self-destructive Behavior."

Dorothy Burwell, associate professor, faculty of nursing, University of Toronto, and Patricia Delbridge, founder and former executive director of the Ottawa Distress Centre, a telephone service for crisis intervention, were resource persons for the two-day meeting.

"After the initial response to the suicidal act, it is important that a total care package be devised for each patient," Delbridge told her audience. "By total care I don't mean round-the-clock company and custody, but a care package that recognizes that in 60 percent of attempts, we are dealing with an at-risk period that may be for the duration of the crisis but may also return at each crisis or indeed become a way of life."

The speaker, who is presently director of Help the Aged, a British agency now extending its operations to Canada, stressed the importance of "Caring." "About the only thing experts agree on," she said, "is that when a nurse, counselor or friend thinks someone is suicidal, the best thing he or she can do is listen and sympathize." Burwell, who was formerly director of nursing education at the Clarke Institute of Psychiatry in Toronto, reminded her audience that "modern science has uncovered only the tip of the iceberg when it comes to communication between humans." She described Crisis Centre volunteers as more advanced than the professions at breaking down barriers between people.

Panel participants included Ryllys Cutler, associate professor, faculty of nursing, and Kenneth Fuller, director of counseling services, UNB. The workshop was sponsored by The New Brunswick Association of Registered Nurses and the N.B. Department of Health, in cooperation with the UNB Department of Extension Services.

MARN members Support PCWM Brief on rape

The Board of Directors of the Manitoba Association of Registered Nurses has given its support to a Brief on Rape prepared by the Provincial Council of Women of Manitoba. The Brief, which was unanimously approved by the Manitoba Council of Women, has been submitted to the National Council of Women and is being considered for inclusion in its annual presentation to the Canadian government in November.

MARN representatives have requested Directors of the Canadian Nurses' Association to consider endorsing the Brief at their meeting in February.

In the Brief, the PCWM emphasizes the need to recognize rape as a "crime of violence" rather than simply a sexual offence. "The Criminal Code presently attaches significantly greater importance to the sexual act than to other aspects of the attack," the Brief points out. "Women who are raped are indeed assaulted, although the law does not emphasize this aspect."

The PCWM recommends legislative amendments to recognize rape as sexual assault under the general heading of assault, with specifications of various forms and degrees of assault. Making the length of sentence correspond to the degree of assault, would help to place the offence of rape in its proper perspective according to the Council. The Brief contains a summary of the Council's reaction to recent proposals by the federal Minister of Justice to amend the Criminal Code respecting rape, as well as related recommendations.

The 10 recommendations include one suggesting changes in courtroom procedure "to spare the rape victim as much embarassment and indignity as possible, for example in the display of intimate apparel and questioning as to previous behavior." The Council stresses the need for liaison between the medical, legal and police professions and recommends expansion and strengthening of counseling services, review of methods of interrogation, and medical procedure.

The Council also notes the need to "prepare girls to be less submissive so as to begin to eliminate their vulnerability to attack."

"The school physical education curriculum should provide female students with courses in basic self-defense skills at an appropriate time in their development. Self-defense may not be sufficient to repel an attack, but it would make girls/women more familiar with situations they should avoid; it would also teach girls/women how to think their way out of a difficult situation, be a physical conditioner, and a form of self-discipline. Recent studies indicate that the difference between the physical potential of women and that of men could be greatly lessened by early physical training for girls on a basis comparable to that received by boys. This would encourage girls to reach their full physical potential."

National survey studies Community nurses

If you are one of the roughly 14,000 registered nurses working in community-based settings in Canada, chances are that you will soon be called upon to help describe this aspect of nursing practice.

The Canadian Nurses' Association is presently conducting a national postal survey of nurses to determine the responsibilities, practice setting, education, remuneration and legal protection/status of nurses working in the various public health agencies, occupational health agencies, visiting care agencies, community health centers, physicians' offices, private and commercial nursing agencies, and treatment centers across Canada.

A random sample of 8,000 of the estimated 14,000 nurses working in these settings will soon be receiving questionnaires from CNA. Names of the recipients were chosen by computer on a random basis and anonymity is assured by the principal investigator.

CNA requests the cooperation and assistance of all nurses who receive questionnaires.



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5'2"	90-140 lbs.	141-190 lbs.	90-140 lbs.	141-150 lbs.	155-190 lbs.
5'3"	90-145 lbs.	146-195 lbs.	90-135 lbs.	136-155 lbs.	160-195 lbs.
5'4"	90-145 lbs.	146-200 lbs.	95-130 lbs.	131-160 lbs.	165-195 lbs.
5'5"	90-145 lbs.	146-200 lbs.	100-125 lbs.	126-165 lbs.	170-195 lbs.
5'6"	90-145 lbs.	146-200 lbs.	105-120 lbs.	121-165 lbs.	170-190 lbs.
5'7"	95-145 lbs.	146-195 lbs.	110-115 lbs.	116-165 lbs.	170-185 lbs.
5'8"	100-145 lbs.	146-190 lbs.		115-160 lbs.	165-180 lbs.
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News

Canadian women at work "La différence" persists

The 1975 edition of Facts and Figures on Women in the Labour Force is out and in it are some interesting statistics that indicate, in the wake of International Women's Year, some important differences that still persist.

In 1974, there were 3,324,000 women at work in Canada. They made up 34.4% of the total labor force. A decade earlier, in 1964, working women comprised only 28.4% of the labor force. In 1974, 39.7% of all women 14 and over worked, an increase of almost 10% over 1964 (30.5%). For men, the "participation rate" is currently 77.3%.

Nurses, as an occupational group, fare better than many others. Women make up 93.7% of all nursing graduates (except supervisors) and male nurses, on the average, earn *only* $400-$500 a year more than female nurses. This compares with a $2,300 - $12,000 gap between male and female secretaries! The difference of $400 a year between the salaries of male and female nurses, ages 25 - 34, with some university training, increases to a more significant $5,000 in the same group between the ages of 55 and 64. (In 1970, the average salary of male nurses between 55 and 64, with some university training, was $13,096, while that of their female counterparts was $7,800).

If nursing supervisors are considered, the results are even more indicative of persistent differences. Although 94% of nursing graduates are women, only 91% of all supervisory positions are filled by women. Looked at another way, 24% of all males in the nursing profession are supervisors; only 18% of women in nursing hold supervisory positions.

Some other highlights of the report are:

- There were 1,084,000 working mothers in Canada in October 1973, representing 35.1% of all mothers. The largest number of working mothers were 25-34 years old; in this group 39.7% of all mothers were working .
- In 1974, women represented 73.9% of all persons employed in medicine and health occupations.
- The participation rates of women in the labor force in 1974 ranged from 43.3% in Alberta to 28.3% in Newfoundland.
- In 1974, 25.2% of all employed women worked part-time; the comparable percentage for men was 6.2%.

Alberta research team Receives H & W grant

Two nurses are part of a four-member team from the Division of Health Sciences Administration, Faculty of Medicine, University of Alberta, Edmonton, that has been awarded a research grant to develop and test an assessment instrument for Patient Classification by Types of Care.

The grant by the National Health Research and Development Program of Health and Welfare Canada, is in the amount of $92,695 for the first 18 months of the 27-month project.

The research director of the project is Peggy Overton, a registered nurse employed in full-time research in the Division of Health Sciences Administration at the University of Alberta. The second nurse associated with the project is Fernande Harrison, a health services administrator at the Alberta Hospital Services Commission, who is also member-at-large for nursing administration for the Canadian Nurses' Association.

The principal investigator for the project is Dr. Kyung Bay whose area of expertise is research methodology. Dr. David Flathman is the fourth member of the team. The research will build upon the definitions and descriptions of Patient Classification by Types of Care outlined in *The Report of the Working Party on Patient Classification to the Advisory Committee on Hospital Insurance and Diagnostic Services,* National Health and Welfare, Ottawa, 1973. The system will be tested out in extended care and selected acute care settings in Alberta. The exact location of the demonstration project has not yet been decided.

Fire costs up In U.S. hospitals

The National Fire Protection Association (NFPA) reports that fires in hospitals and mental institutions in the United States are occurring more frequently and costing more than ever before.

NFPA statistics show an increase of nearly 200 percent in the number of fires reported in health care institutions in the U.S. during the past six years. Property loss over the six-year period is estimated at close to $80 million.

Several factors help to explain the dramatic jump in dollar losses — hospitals have expanded their facilities, increasing the areas exposed to fires; more people are using hospitals; there is more electrical equipment and much of it is more complex. The rate of inflation in recent years also lends an exaggerated character to these totals.

"Health care institutions must have adequate motivational fire prevention programs," states Charles S. Morgan, President of NFPA. "Sometimes the possibility of fire in a hospital seems remote but the statistics tell a different story.

A recent U.S. survey (not by NFPA) of 75 hospitals with various bed capacities (50 to 600) disclosed that a high percentage of fire incidents that occurred in hospitals had not been reported and never became statistics. Survey director Charles K. Spalding of Boston notes: "Fortunately, only a small percentage of hospital fires are allowed to become serious. It is the small fires that produce little damage or concern that should attract the attention of those responsible for hospital fire prevention."

He also reports that the "majority of fires were attributable to the careless use of smoking materials. Patients' visitors were often responsible for the unexpected situations, for they are usually unfamiliar with areas where specific controls are required.:. nurses' lounges were found to be common areas for the wastebasket-type fire."

Spalding says that a proven reason why hospital fires become serious situations is the lack of effective educational programs for personnel, especially those working the night shifts. The most common mistake is neglecting to summon professional (fire department) help before attempting other action. Virtually every fire involving injury or death that has been reported in recent years is traceable to the failure of hospital personnel on the scene to follow established fire plans.

NFPA findings are that most hospital and mental institution fires (55.2 percent) occur in patients' rooms, with the second and third highest areas being storage (15.3 percent) and lounging rooms (6.8 percent). The most common source of ignition was smoking materials (50.8 percent) and wearing apparel was the material ignited most often (68.8 percent).

New health services Program planned

A northern Ontario university, Lakehead University School of Business Administration located in Thunder Bay, plans to offer what it believes to be the first Canadian undergraduate degree in Health Services Administration beginning in September, 1976. The three-year program leading to a B. Admin. is open to both full-time students and part-time employees in hospitals and other health care institutions.

Allowance is being made for relevant credits and courses previously undertaken. Of the fifteen credits, ten provide a broad education in administration: principles, decision making, economics, basic accounting personnel management, finance etc. The major includes many options, and courses in Canadian Health Care Organization, Hospital Administration Materials Management, Community Health, Sociology of Medicine and a research project.

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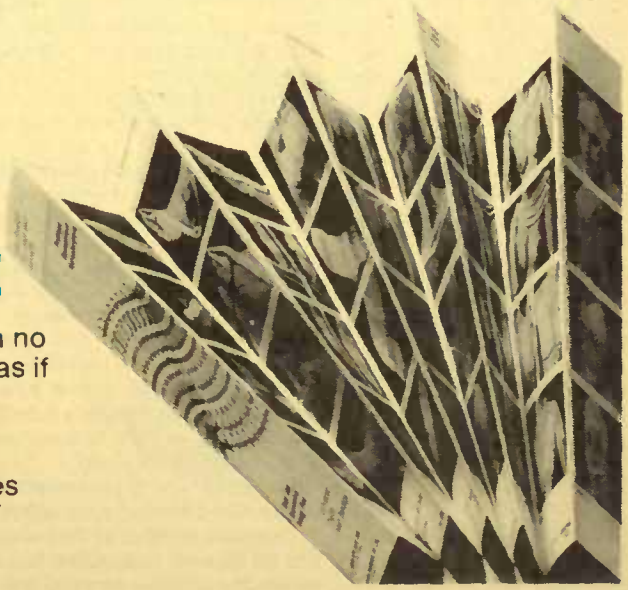


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News

Good health The yoga way

Recipe for health: Start with exercise, a few simple postures to stretch the muscles and keep the body in tune. Add lots of fresh air, sports, a dash of country living. Eat healthy food. Calm yourself. Breathe deeply. Reach inside yourself for inner happiness.

Sound promising? This was the message of Suzanne Piuze, a yoga teacher from Montreal, who has done much to adapt these classical teachings to the North American way of life. While in Ottawa recently to promote her method of teaching yoga, she visited CNA house to talk to journal staff about yoga and its relationship to the medical profession.

"To me, yoga is an art of better living, and also a school of happiness. It's a way to find peace of mind, to control your body as well as your mind, instead of being a slave all your life to your environment, to your work, to sadness, to whatever comes from the outside. Yoga helps you to get inside, deep inside and find happiness where it really is," she said. To help people find their way, she teaches a combination of the many forms of yoga, including Hatha Yoga (yoga of postures) and Raja Yoga (yoga of the mind) at her studio in Montreal and a live-in Yoga Centre in the Laurentian Mountains.



"You have to start with your body, but at the same time something happens while you are so aware of your muscles, of your health, of movement, you also control your mind because you have to think only of what you are doing." The exercises themselves, she says, are only one way to cleanse the mind. She also teaches transcendental meditation, a technique to calm the mind and stop the inner "movie camera" from producing its constant flow of images. To facilitate this type of relaxation students repeat a *mantra*, usually a Sanskrit word, over and over as they follow their breath. Because the word has no meaning for them, it doesn't bring to mind any particular thoughts or worries, but does help to push out other thoughts that seem to control the mind.



Two CNA journal staff members, Viviane Marcil (assistant editor, L'infirmière canadienne) and Carol Thiessen, right, (The Canadian Nurse) interview Canadian yoga expert, Suzanne Piuze.

Nutrition is also an important part of her teachings. She does not smoke, nor drink coffee and avoids eating sweet foods like cakes and pies. She does drink tea, however, and serves her students at the Yoga Centre a variety of herbal teas, specially mixed to take advantage of their medicinal effects.

Far from regarding it as quackery, Piuze says that more and more doctors are recognizing the beneficial effects of yoga, particularly for psychosomatic diseases and cases where relaxation is important, e.g. heart conditions, and many are sending patients to her. She stresses that yoga is basically preventive and should complement medical advice rather than being used as a substitute for it. To this end she has studied anatomy, physiology and acupuncture, and is committed to a personalized form of yoga where postures are adapted for the individual and his physical capabilities. She also adapts the postures for other groups, including expectant mothers who can take advantage of her prenatal yoga classes to learn to breathe properly and relax. In fact, she says, many of the breathing exercises taught in community prenatal classes have their origin in yoga.

Among her clientele are many nurses who come for personal reasons and "sometimes because they want to get away from pills, just the sight of them." Asked how nurses can apply what they learn to their jobs, she replied: "The best way to teach is by example. Instead of telling someone to do this or that, if you apply it to yourself, it reflects. Also, if they are more aware of their patients, if they are 100 percent with them, it helps too. With yoga, when you are present, you are *really* present." She also suggested that nurses can encourage good health "by telling patients that when they get out of the hospital they should go near the sun as much as they can and eat better. They should walk, they should practice sports, they should drink lots of water between meals, they should go to the country as much as possible, they should not drink too much coffee."

In her own way, Suzanne Piuze is trying to spread the message of "yoga for health." She has published three books, La Santé par le Yoga, Hatha Yoga, and Yoga Sex; she teaches yoga in a studio in Montreal; she gives one half hour a week of yoga on community television; and she teaches adolescent girls in jail one night a week. In addition she publishes brochures encouraging those who are interested to come to her Yoga Centre in Eastman for intensive weeks or weekends of yoga, seminars on physiology, stress, etc., fresh air, sports and healthy surroundings.

AARN celebrates Diamond jubilee

The Alberta Association has announced that the theme of its Diamond Jubilee Celebrations will be "Co-ordination of Health Care Services." In the 60 years since it was established, the AARN has grown from the initial nucleus of 12 members to a total of more than 35,000 registered nurses at the beginning of 1976.

Looking back on the history of the association's preliminary steps towards organization, a spokesman for the AARN, recalls:

In 1909, the embryonic Canadian Nurses' Association set out to encourage nurses to organize at the provincial level. Before this, nurses in the various provinces were not organized as a provincial body but as alumnae within the provinces. In Alberta, prior to 1916, local nurses' groups existed in four major cities. Local registries of qualified nurses for private duty nursing were also kept.

The main reason behind the development of provincial Graduate Nurse Associations was that trained nurses found themselves competing for status and wages with 'nurses' who had little or no training. No legal controls to curb this situation existed. Trained nurses in each province therefore united to lobby for Provincial Registration Acts that would establish uniform standards for preparation and graduation and give qualified nurses legal status.

When the Alberta (Act) developed by the AARN, was passed in 1916, the province became the third in Canada to enact nursing legislation. Nova Scotia (1910) and Manitoba (1913) had passed acts incorporating registration procedures shortly before this time.

The AARN 1976 annual convention takes place May 11-14 in Edmonton.

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Calendar

March 23 - May 11, 1976
Course: "Conserving and Promoting Health for the Mentally Retarded," Tuesday evenings at the McLennan Physics Building, University of Toronto. *For information contact: Dorothy Brooks, Continuing Education, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ont., M5S 1A1.*

March 31 - April 1, 1976
National Nephrology Forum: A Conceptual Approach to Patient Care at Hyatt on Union Square, San Francisco, CA. *For information write to: American Association of Nephrology Nurses and Technicians, Two Talcott Road, Suite 8, Park Ridge, Illinois 60068.*

March 30 - April 1, 1976
21st annual convention of the American College of Nurse-Midwives to be held at Stouffer's Riverfront Towers, St. Louis, Missouri. On March 29, a workshop on Adolescent Health Care; April 2 workshop on Attitude Reassessment for the Sexual Counselor. *For information, write: American College of Nurse-Midwives, 1000 Vermont Avenue, N.W., Washington, D.C. 20005.*

March 24-27, 1976
Association for the Care of Children in Hospitals conference to be held in Denver, Colorado. *For pre-registration information, write: Lynn Moulthrop, ACCH Colorado Affiliate, P.O. Box 613, Aurora, Colorado 80010.*

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April 1 - 3, 1976
Workshop: Current Concepts in the Care of the Diabetic to be held at Jasper Park Lodge, Jasper Alberta. Information from: Continuing Nursing Education Division of Continuing Medical Education, Clinical Sciences Bldg., University of Alberta, Edmonton, Alta. T6G 2G3.

April 2 - 4,1976
Biennial meeting of the Northwest Territories Registered Nurses' Association to be held in Yellowknife, N.W.T.

April 3 - 4, 1976
"Nursing Today in Emergency Care" to be held in Vancouver. Apply to: Continuing Education in the Health Sciences, P.A. Woodward Instructional Resources Centre, University of British Columbia, Vancouver, B.C. V6T 1W5.

April 9 - 10, 1976
"Practical Application of Psychosomatic Obstetrics and Gynecologic Concepts to Patient Care" — conference to be held in Chicago, sponsored by the Canadian and U.S. sections of the International Society of Psychosomatic Obstetrics and Gynecology. *For information, write: Toby Hofslund, 1307 East 60th Street, Chicago, Ill. 60637, U.S.A.*

April 21 - 24, 1976
Symposium on fetal monitoring to be held at Chateau Frontenac, Quebec City.In English and French, with simultaneous translation, information from: Dr. Adrien Bastide, Hôpital Saint-François d'Assise, 10 de l'Espinay, Quebec, Quebec, G1L 2H1. (Tel: 418-688-8710)

April 23 - 24, 1976
Interdisciplinary Respiratory Disease Conference sponsored by the New Brunswick Tuberculosis and Respiratory Disease Association will be held at the University of New Brunswick in Fredericton, N.B. *For further information write: Alma T. Leclerc, Program Director, New Brunswick TB and R.D. Association, 123 York Street, Fredericton, N.B. E3B 5E3.*

April 26 - 30, 1976
National conference of Operating Room Nurses and Biennial Institute of the British Columbia Operating Room Nurses Group to be held at the Vancouver Hotel. Information from: Ellen Schodt, Chairman, Registration Committee BCORNG, 103-930 Glenacres Drive, Richmond, B.C.

April 29 - 30, 1976
Session: Current Nursing Methods and Resources in Coronary Care to be held at School of Nursing, University of Alberta. Information from: Continuing Nursing Education Division of Continuing Medical Education, Clinical Sciences Bldg., University of Alberta, Edmonton, Alta. T6G 2G3.

April 29 - May 1, 1976
Annual Meeting of the Registered Nurses' Association of Ontario to be held at the Royal York Hotel, Toronto,

May 11 - 14, 1976
Alberta Association of Registered Nurses convention to be held at the Edmonton Plaza Hotel . Theme: Coordination of Health Care Services.

May 12 - 14, 1976
Annual meeting of the Registered Nurses' Association of British Columbia to be held at the Vancouver Hotel, Vancouver.

May 16 - 18, 1976
Manitoba Association of Registered Nurses annual meeting to be held at the North Star Inn, Winnipeg.

May 17 - 19, 1976
Cardiology '76: third annual conference on cardiac care for doctors and nurses, to be held at Humber College, Toronto. Information from: Conferences and Seminars Office, Humber College, P.O. Box 1900, Rexdale, Ontario.

May 28, 1976
Annual meeting of the Registered Nurses' Association of Nova Scotia is to be held at the Hotel Nova Scotian, Halifax, Nova Scotia.

June 8 - 10, 1976
Annual meeting of the New Brunswick Association of Registered Nurses to be held at the Playhouse, Fredericton.

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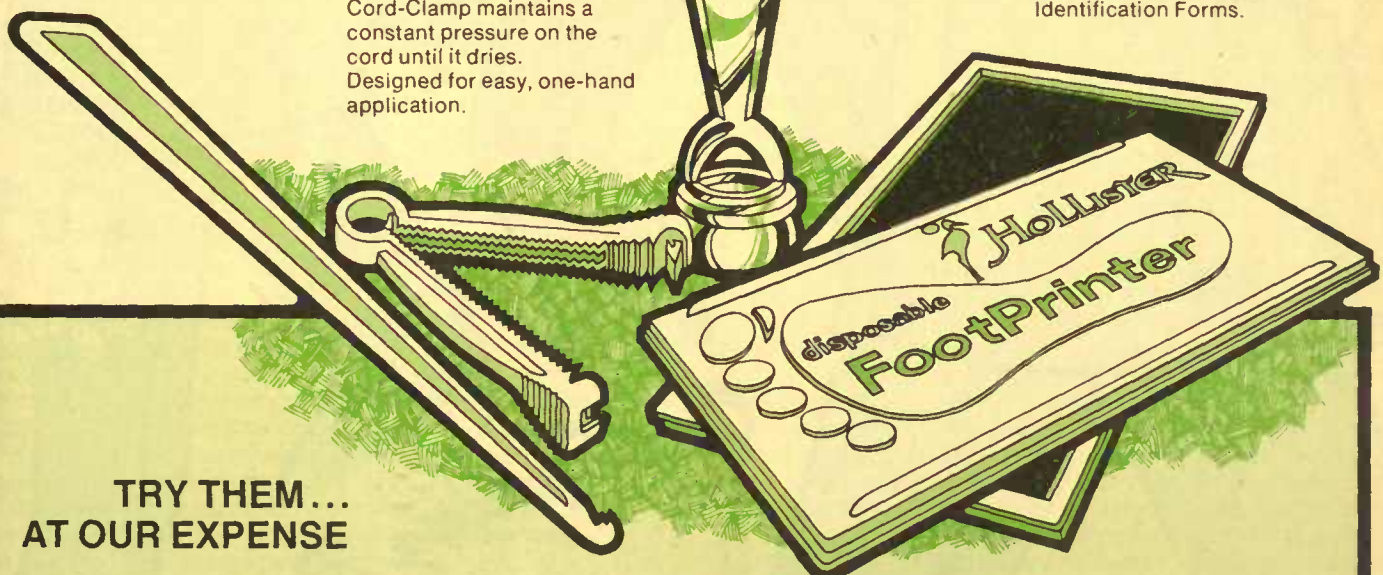
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Fernande Harrison author of this month's forum, is CNA member-at-large for nursing administration. She is Health Services Administrator — Nursing, Alberta Hospital Services Commission

Frankly Speaking about nursing administration

A Contemporary Dilemma in Nursing Administration

Fernande Harrison

The folklore of Central America offers a thought-provoking anecdote describing the behavior of a monkey and a fish caught in a flood. The monkey was able to climb into a nearby tree, and from this secure perch, he watched the fish struggle against the turbulent waters. Finally he grew impatient with the struggles of the poor fish and called down, "You should be as clever as I am, and come up here." But the fish did not reply and continued his fight with the waters. Finally the monkey could stand it no longer. He reached down and abruptly pulled the fish from the water. The fish, of course, did not respond well and lay there gasping with what little breath he had. Observing that the fish really appeared about to die, the monkey threw it back into the water and forever after proclaimed to anyone who would listen that there was no use trying to do anything for fish, because they did not show proper gratitude when they were helped.

This anecdote can be applied in a very interesting manner to the current situation of most hospital nursing administrators. Like the fish, they are caught in a "flood" of budgetary controls and the pressure of increasing patient service needs. The monkey and his actions are represented by those who demand immediate solutions to these very complex problems.

Nurses at various levels of responsibility have been exposed to strict economy measures. Budgetary control in coming months could easily dishearten the most conscientious nursing service directors. Yet, while the federal and provincial economic measures constrain the operation of nursing service departments, demands for health care services are rising steadily. This presents a genuine dilemma for nursing administrators; realistic solutions to the problem are not easy to visualize. In the original anecdote, the fish turned a "deaf ear" to the monkey's suggestion to climb up into the tree. Even though the fish's decision was wise, the monkey was frustrated by his seeming stupidity. It appeared obvious to the monkey that the fish didn't know what he was doing.

Nursing Administration

High administrative nursing directors often turn the same "deaf ear" to suggestions from nursing staff. Their reasons may be valid but often they are not obvious to others. The suggestion may not be useful to the administrator, for several reasons, even though to the nursing staff it seems perfectly logical and straightforward. Staff members quickly become frustrated with the apparent inability of administration to cope effectively with the situation and this leads to anger and bad feelings.

Similar misunderstandings may occur when administrators must make severe budget cuts to particular departments. Supervisors of such areas may feel personally insulted by the reductions and interpret them as an insult to their personal competence and the significance of their department. Just as the monkey challenged the decision of the fish, the nursing staff question not only the fairness, but the wisdom, of administrative decisions and actions. The intensity of these feelings and the way in which they are expressed largely determines how constructive or detrimental such criticisms can be. Administrators who are skillful in dealing with their staff could use this energy and drive to work out a better solution to many problems.

Focusing for a moment on the fish, one wonders if administrators cannot learn from his adaptive behavior. Even though he took a rather dogged approach to his problem, nevertheless, he survived. Survival in terms of maintaining the quality of patient care under tight budgetary control will be a great challenge for administration in the months and years ahead.

The Challenge

While individual approaches will necessarily vary to reflect local circumstances, many nursing administrators will have to rethink the philosophy and objectives governing their department. Some will go further. Policies, procedures and ritualistic practices influencing individual care plans of patients and underlying staffing patterns will be carefully reviewed. Some leaders may approach the dilemma from the point of view of resource allocation. Given that fair decisions can only be made on the basis of up-to-date and reliable data, activities will be geared to upgrade the information base upon which staff are allocated around the clock and throughout the week. Peaks and valleys in the weekly work load will be identified and positive steps taken to even out sporadic demands for nursing hours. A system of patient classification according to needs might be instituted. The relationships between nursing and other groups in terms of their complementary roles, more appropriate use of personnel, and economy, might also be seriously considered.

A critical review of "what is" and inquiries into "what could be" are logical steps in the solution of any problem. Just as the fish had to swim because it was the most natural thing for him to do, so the nursing administrator must take the most basic steps to solve her problems. The most familiar steps would obviously be an appraisal of current practices and alternative approaches, with the aim of maintaining quality services within the present budgetary constraints. The introduction of improved information systems to achieve superior managerial decisions might be termed by "outsiders" a very simplistic and elementary approach to the "flood" of budget cuts and the heavy demand for patient service. But is it really, if it means survival? If there is anything to be learned from the fish and his actions, it is that survival depends upon just this type of natural action.

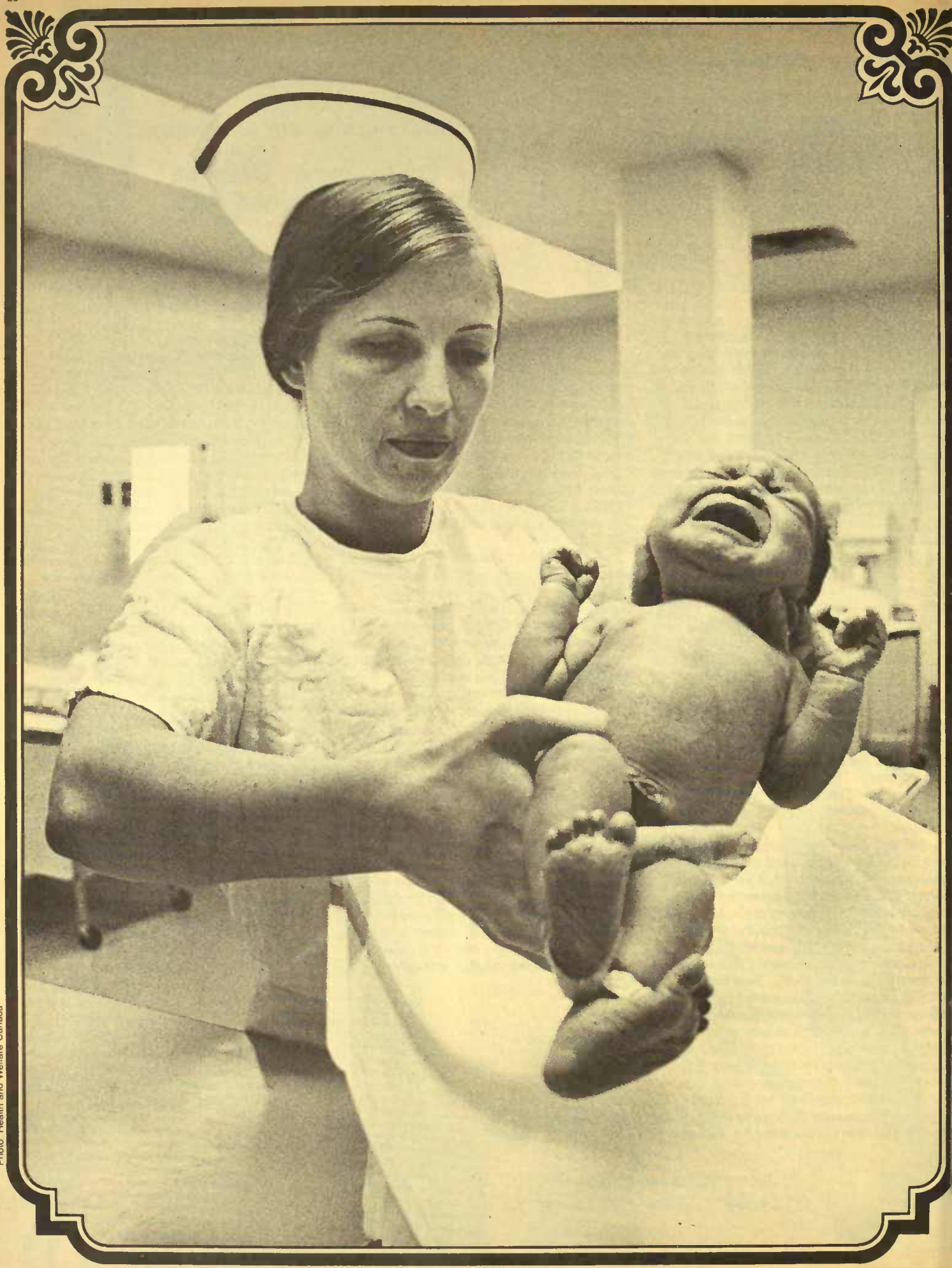


Photo: Health and Welfare Canada

PHYSICAL ASSESSMENT OF THE NEWBORN

Viviane Marcil

Birth is a most traumatic experience and negotiating successfully from intrauterine to extrauterine life is a major challenge to the neonate. In fact, statistics reveal that the largest percentage of infant deaths occur during the first 24 hours after birth and the great majority of these occur in the first hour of life.

In the light of this, the nurse has the important function of assuming responsibility for immediate, careful, and constant observation of the newborn; she is the one most likely to detect the first clue that all is not well with the infant. Not only must she be thoroughly familiar with the physical mechanisms of the neonate in order to provide optimum supportive care in the stabilization of respiration and temperature, but she must also have broad and specific knowledge of the range of usual physical and behavioral findings of the normal infant in order to recognize those that indicate pathology and require immediate medical attention. One of the best means of detecting any abnormality is to proceed with careful, thorough, and systematic physical examination of the newborn.

Before the nurse proceeds with the actual examination of the infant, she should review the antenatal history (health of the mother during pregnancy, Rh typing, complications of pregnancy, and drugs taken) and the birth history (kind and duration of labor, type of delivery, sedation or anesthesia, resuscitation required, Apgar score, birth weight and length, and gestational age) as they may reveal pertinent information as to where abnormality or pathology may exist. The infant's body temperature, respiratory rate, pulse rate, cry and color are also evaluated. Careful observation of the state of consciousness and general activity also provide valuable general impressions that can be confirmed or modified later.

Although the sequence of the examination should normally be standardized, the nurse may adapt the system of examination to the particular infant and situation. For example, it may be best to examine the chest and abdomen first if the baby is sleeping or to examine the mouth, palate, gums and facial contractions if the newborn is crying. Whatever the approach, the nurse should make sure that no part of the examination has been missed.

Afterwards, a detailed recording of the examination is made in order to provide valuable base-line data for the physician who will later examine the child himself, and for other nursery staff who will subsequently be responsible for the care of the infant. A standardized system of recording makes it easier for others to identify specific information more efficiently.



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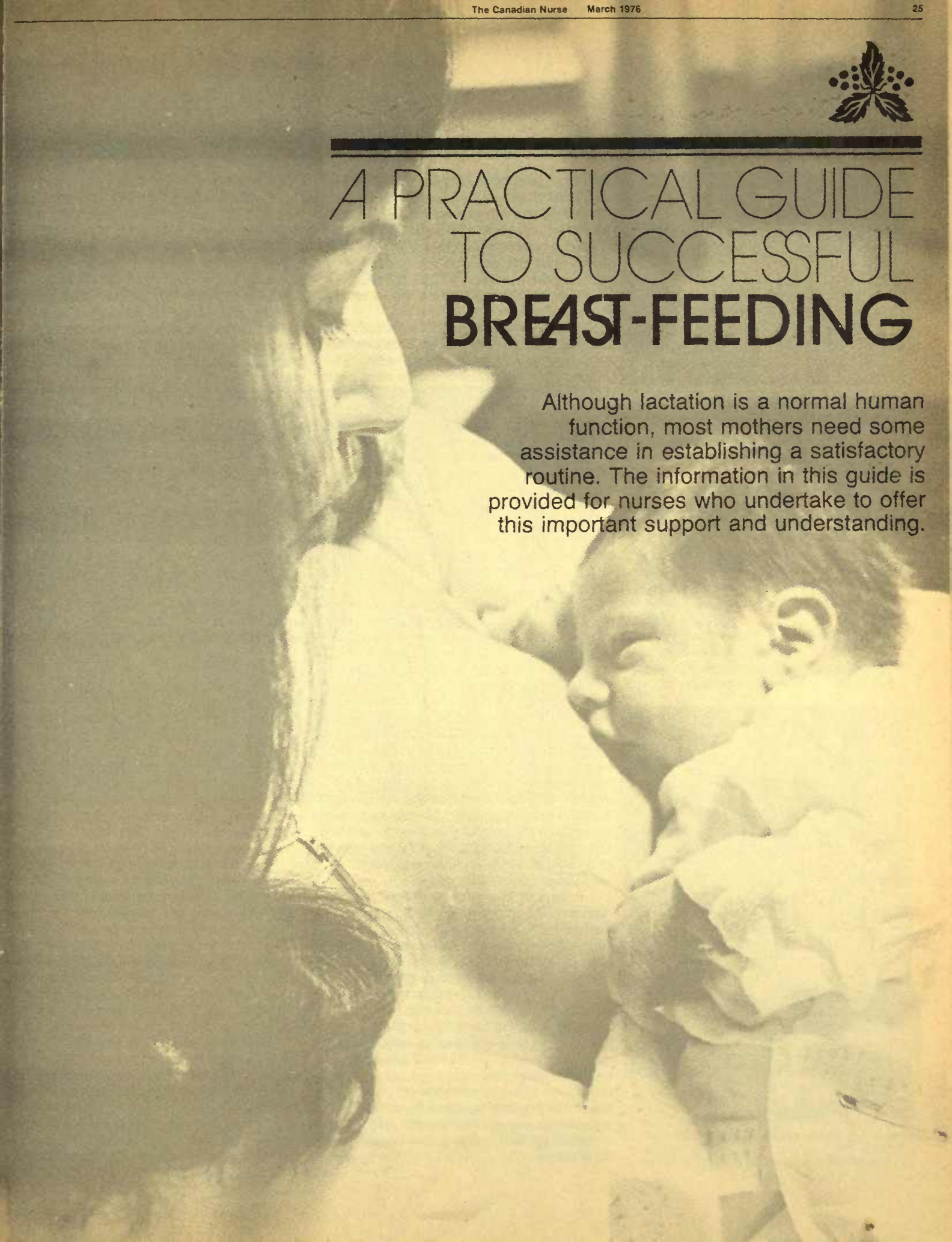
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		Usual findings	Normal variations	Abnormalities
Head	Size	35 ± 2.5 cm circumference		<33 cm - microcephaly (eg. anencephaly) >38 cm - macrocephaly (eg. hydrocephalus)
	Shape	Molded, if vaginal delivery, round if cesarian section	Asymmetry due to molding, hematomas or edema (eg. caput succedaneum, cephalhematoma)	
		Palpable anterior and posterior fontanels and sutures	Posterior fontanel may be closed	
		Anterior fontanel flush with neighboring parts (can be expected to be slightly depressed when child is in sitting position)		Tension of the anterior fontanel (to be determined when child is in sitting position) — depressed (eg. dehydration) — bulging (eg. intracranial pressure) *Notify physician immediately*
		Sutures are normally felt as ridges immediately after birth or as depressions within a day	There may be overriding of the sutures *Observe and notify physician*	Hemorrhage (intracranial) Depressed skull fracture *Notify physician immediately*
Face	Symmetry	Symmetry between left and right side of face		Asymmetry between left and right side of face (eg. congenital malformation, hemiplegia)
		Symmetrical contractions of face when infant cries or grimaces		Movement of only one side of face when infant cries (eg. facial nerve palsy)
	Color	Red		Pallor, gray color Persistant cyanosis (eg. congenital cardiac malformations)
Eyes	Symmetry	Correct placement on face in relation to each other		Centered or deviated to right or left
	Eyelids	Edema due to instillation of silver nitrate		Marked edema or inflammation
		Blink reflex present		Drooping Setting-sun sign
	Discharge	None	Moderate discharge from irritation by silver nitrate	Purulent
	Cornea	Bright and shiny		Hazy or dull
	Pupils	Round shape		Oval or irregular shape Constricted (eg. cerebral paralysis)
		Equal and reacting to light	Reaction to light discernible	Fixed and dilated
	Iris	Dark or slate blue		
	Sclera	Bluish-white		Hemorrhage Jaundice
	Retina	Red reflex		Opacity of lens
	Coordination	Nystagmus usually present when child rotated laterally. Does not persist when replaced in crib	Occasional uncoordinated movements	Persistent uncoordinated movements
Ears	Shape	Well-formed	Preauricular papillomas may be present	Malformations (eg. branchial clefts)
		Cartilage present	Amount of cartilage varies (lessened amount is usually a sign of prematurity)	
		Upper part of ear should be on same plane as angle of eye	May be folded or creased	Malformations (eg. low placement)
	Hearing	Blinking of the eyes, momentary cessation of activity or startling indicate positive reaction to sound		No response to sound
		Moro reflex		No response to Moro reflex (eg. intracranial hemorrhage
Nose	Symmetry	In midline of face		Deviated to right or left
	Shape	Appears flattened		Malformation Unusual flattening
	Patency	Infant should breathe easily through nose when mouth closed	Some mucus present in nares may interfere with free breathing	Flaring of nares (eg. obstructed airway, atelectasis) *Check for other signs of respiratory distress*

		Usual findings	Normal variations	Abnormalities
Mouth	**Lips**	Pink Rooting reflex	May have transient circumoral cyanosis	Malformation (eg. cleft lip)
	Tongue	Pink Inside mouth Normal volume	 Short frenulum linguae (insignificant)	Thrush Protrusion Frenulum linguae extending to tip of tongue (may interfere with sucking) Large and thick (eg. Down's syndrome)
	Palate	Pink and well-formed	Epstein's pearls Inclusion cysts	Malformation (eg. cleft palate or unusually high)
	Gums	Pink	Rear gums may be whitish May appear quite jagged Teeth may be present Inclusion cysts	
	Salivation	Scant		Excessive and frothy (eg. tracheo-esophageal fistula)
	Reflexes	Sucking reflex initiated when lips touched Extrusion reflex Gag reflex initiated by tongue blade		Loss of sucking reflex (eg. physiologic jaundice)
Neck	**Appearance**	Short, straight		Masses Distended veins or edema Webbing
	Motion	Head moves freely from side to side and from flexion to extension		Restriction of motion Congenital torticollis Opisthotonus
Chest	**Size**	Averages 30 to 37.5 cm	<30 cm - prematurity	
	Shape	Almost circular		Gross abnormalities Bulging Depressed sternum
	Expansion	Symmetry of movement with respirations		Asymmetrical movements (eg. diaphragmatic hernia)
	Respirations	Rate - 40/min.	May range from 30 to 60/min.	Labored breathing Grunting on expiration Retractions with respirations
	Breath sounds	Vesicular		Rales Rhonchi Wheezes
	Breast Tissue	Present in both sexes	Excessive amount of breast tissue	
	Nipples	Symmetrical placement of nipples	 Milky secretion may be evident	Asymmetrical placement of nipples (eg. fracture of clavicle) Signs of infection Presence of supernumerary nipples below nipple line or in axillary region
	Heart sounds	Rate - 120 to 150/min. Rhythm-irregular following physical or emotional stimulus Quality - first sound (closure of mitral valve and tricuspide valve) and second sound (closure of aortic and pulmonary valve should be sharp and clear		Sounds of poor quality Extra sounds Heard on right side (sign of dextrocardia) Murmurs accompanying heartbeats
Abdomen	**Shape**	Contour cylindrical and relatively prominent		Asymmetry Distension Localized bulging (eg. hernia) Scaphoid abdomen (eg. diaphragmatic hernia) *Check for other signs of respiratory distress*
	Femoral pulses	Present		
	Umbilical stump	Bluish-white Dry within several hours after birth	Umbilical hernia may be present and is usually insignificant	Abnormal redness, bleeding or infection Odor

		Usual findings	Normal variations	Abnormalities
Genitalia	**Size**	In both sexes, tend to appear large in relation to rest of body	Edema present in breech delivery Size of penis and scrotum varies widely	
	Color	Red	May have increased pigmentation in dark-skinned races	
	Appearance	Female: labia minora are quite prominent and protrude over labia majora	Smegma	
			Vaginal discharge - mucoid or blood-tinged	Excessive vaginal bleeding
		Male: prepuce usually adherent to the glans		Malformations (eg. epispadias, hypospadias, phimosis)
		Testicles usually in scrotum	Cryptorchidism	
		Scrotum small and firm or fairly loose, relaxed and pendulous		Hydrocele
		Meatal opening should appear as a slit		Meatal opening appears round
Extremities	**Appearance**	Generally flexed but can be put in full range of motion passively Alignment of parts and presence of all limbs and extremities	May retain in utero position when sleeping	Limitation of movement in any joint (eg. fractures, paralysis) Absence or defects of parts or all of extremities
	Color	Cyanosis may last for several hours after birth		Difference of color or temperature between the extremities
	Hands	Fists clenched Flexion of hand at wrist is approximately 110°; extension is 80° Grasp reflex		Malformations (eg. webbing or presence of extra digits, clubbing of fingers, unusual shortness or curvature of little finger, simian crease on palm of hand)
	Arms	Shoulders abduct from trunk about 120° Range of motion at the elbow		Limitation of motion (eg. fracture, paralysis)
	Feet	Plantar fat makes feet appear flat Grasp reflex Babinski reflex Usually held in varus or valgus attitude but can be straightened without forceful manual stretching Flexion and extension of ankle about 130°	May turn in but can be passively turned out	Malformations (eg. club feet, absence of toes, abnormal spacing between first and second toe)
	Legs	Mild degree of bowing or medial rotation Symmetry of medial skin folds on anterior and posterior thigh		Extra folds or asymmetry (eg. hip dislocation)
	Hip	Range of motion should be about 160° to 170° in flexion and extension Thighs flexed at hip should abduct to an angle of 160° between thighs		Limited abduction of one or both hips (eg. dysplasia, hip dislocation)
Skin	**General Appearance**	Red in color Varies with race and ethnic origin		Pallor; jaundice in first 24 hours of life
		Cyanosis of lips, fingernails, toenails, hands and feet	Harlequin sign Erythema toxicum neonatorum Capillary hemangiomas Lanugo	Generalized cyanosis (eg. cardiac, neurologic or respiratory malformations)
		Tendency to be dry	Vernix caseosa Desquamation (eg. if post-maturity)	Tinted vernix caseosa
	Turgor	Skin of back of lower leg or thigh or of abdomen returns to its former position after release of grasp between thumb and index finger of examiner		Fold of skin persists for several seconds after release
Back	**General Appearance**	Shoulders, scapulae, iliac crests on same plane with each other		Malformations (eg. spina bifida) Abnormal curvature of spine
		Spine straight and easily flexed	Pilonidal dimple over coccygeal area Hair over shoulders and back, especially in premature infants	Pilonidal cyst or sinus Tufts of hair anywhere over the spine, especially over sacrum (eg. spina bifida)
Anus	**Patency**	Proven by adherence of meconium on rectal thermometer	Anus may be irritated by frequent rectal temperatures	Imperforated anus Fissures, bleeding



A PRACTICAL GUIDE TO SUCCESSFUL BREAST-FEEDING

Although lactation is a normal human function, most mothers need some assistance in establishing a satisfactory routine. The information in this guide is provided for nurses who undertake to offer this important support and understanding.

Marie-Elizabeth Taggart

Mothers who choose to nurse their babies need to understand, not only the anatomy and physiology involved, but also the proper procedure for breast-feeding. It is not unusual in obstetrical units, to find nursing mothers with a variety of physical complaints, including dorso-lumbar fatigue after feeding, sore nipples and painful engorgement of the breasts. Unfortunately, these discomforts have not always been predicted, explained or alleviated by the nurse involved and many mothers as soon as they return home, give up their attempts to breast-feed.

Inadequate instruction by medical or nursing personnel is not the only reason that these setbacks occur. Success or failure in breast-feeding depends upon many factors, including contemporary social and cultural attitudes. To illustrate, nursing mothers are often anxious about their ability to maintain an adequate milk supply, even though it has been established that the vast majority of women (85 percent) are physically capable of lactating for six months or longer. Usually, the failure of physiological mechanisms involved in milk secretion and ejection can be traced to psychological barriers that are the result of stress and anxiety.



Evidence also indicates that social attitudes play an important role in determining the success or failure of breast-feeding. Urbanization and industrialization have been accompanied by new social values. In fact, it could be said that industrialization has transformed breast-feeding into an outdated, archaic practice, at the same time that it has elevated artificial feeding into a positive symbol of economic status. In today's society, the breast is too often perceived as primarily a sexual symbol. Some mothers have developed a negative body image concerning breast-feeding; for them, this procedure is a disgusting or degrading act.

The attitude of members of the immediate family and close friends also affects the success or failure of the program. Recently, there have been indications of a trend towards renewed interest and enthusiasm about breast-feeding. College or university -educated women, along with advocates of "natural foods," are among the strongest advocates of a return to this method of nourishing the baby. Some of these supporters have been influenced by publicity surrounding possible long-term harmful effects of artificial feeding on the baby's metabolism. Studies have been released suggesting that these include: neonatal hypocalcemia; overtaxing of the baby's kidneys with electrolytes as a result of the too early introduction of semi-solid and salty preparations; and the early appearance of a taste for sugar and consequently a long-range risk of tooth decay.

In view of this renewed interest, it is the responsibility of today's nurses to equip themselves to provide new mothers with understanding, support and education. Although lactation is a normal human function, most mothers need some assistance in learning how to breast-feed successfully. The aim of this article is to help nurses and, indirectly, mothers become more knowledgeable in this area by describing the main stages of an educational program on breast-feeding. This includes a brief discussion of the advantages of breast-feeding and suggested educational approaches appropriate for each stage in the maternity cycle: I) prenatal, II) in-hospital, and III) at-home.



Advantages

Breast-feeding offers certain advantages over artifical feeding that should be explained to the mother. For example:

- The beginning of lactation triggers a hypophysial reflex that induces an ocytocic hormonal action on the uterus. This causes contractions that,in turn, facilitate its involution and help to effect a return to its normal state .
- The mother's milk contains various anti-infective properties that ensure the baby's protection against intestinal infections causing diarrhea, especially those caused by Escherichia Coli. Moreover, the mother's milk seems to provide a degree of protection against pathogenic agents such as poliovirus and enterovirus. In addition, epidemiological studies conducted in developed countries show that the incidence of upper respiratory infections is lower among breast-fed babies.
- Pottenger and Krohn (Ashley Montagu 1971) found that breast-feeding facilitated adequate development of the peri-buccal muscles and the dental arch so as to help prevent the protrusion of teeth that would eventually require orthodontic repair.
- It has been proven that the incidence of colic, food allergies and eczema is lower among breast-fed babies.
- Psychologists agree that breast-feeding provides the baby with maximum oral gratification and establishes irreplaceable bonds of affection between mother and child.

I Pre-Natal Instruction

About the middle of the second trimester, or at the beginning of the third, the nurse responsible for prenatal teaching may begin to provide some general advice, a brief theoretical explanation and some illustration of the procedures involved in breast-feeding.

Some helpful suggestions

The mother contemplating breast-feeding needs to know, for example, that during pregnancy, the size of the breasts will gradually increase and that this will necessitate buying progressively larger brassiere sizes. These bras should have wide shoulder straps for adequate support; should be washable and have properly fitting cups. They should not be rubber-lined, strapless or boned.

Brief air or sunbathing may be recommended to strengthen and toughen the nipples. A terrycloth facecloth or towel may be used to rub the breasts vigorously night and morning.

During her daily bath the prospective mother should wash her breasts first using plain water and avoiding soaps or perfume that

may dry out the aerola and eventually cause chapped nipples. A body oil, containing lanolin, cold cream or baby oil, or one prescribed by the doctor may be applied to keep the nipples and aerola flexible.

Mothers who have chosen to breast-feed their babies should have their breasts examined by either the nurse or doctor in order to ensure that the nipples are tractile, since successful breast-feeding depends to a large extent on the baby being able to draw the nipples against his hard palate when sucking.

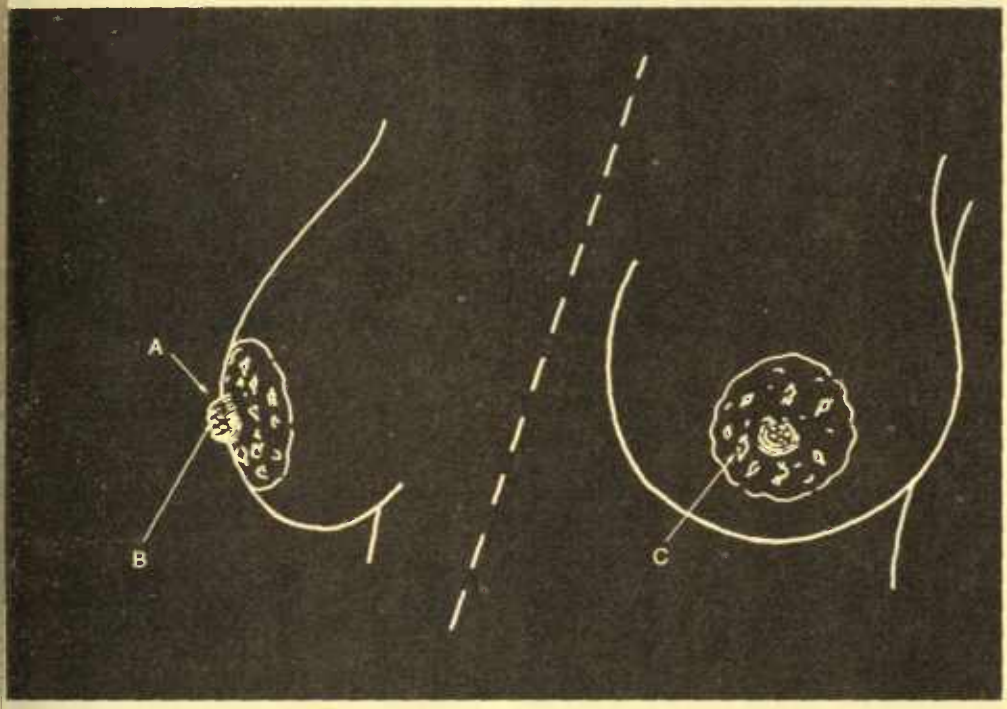


Fig. 1 — external view of breast
A Papilla
B openings for milk to flow (nipple)
C Montgomery's glands (glandulae areolares)

Postpartum is hardly the time for a mother to discover, to her painful surprise, that her breasts are not suited to breast-feeding. Most nipples are tractile when held between the thumb and index finger. This means that the nipple begins to harden and swell when subjected to stimulation with the fingers. Some women, however, have retractible nipples that contract rather than swell when stimulated. In such cases, the exercises that will be described later may be useful. The mother with retractible nipples can be helped by wearing Woolwich cups (available from the La Leche League) for at least eight hours a day. These cups follow the shape of the breasts very closely and force the nipples to protrude.

Mothers hoping to breast-feed their babies may wish to join the La Leche League Association to obtain free advice and encouragement.

Physiology of Breast-feeding

In order to successfully breast-feed her baby, the mother must grasp the basic concepts involved in the anatomy and internal functioning of the breasts. If this explanation is provided in straightforward and simple form, the mother will understand the lactation process and will be less anxious about her ability to nurse her baby.

Patient teaching should include:

- Examination of the outer aspects of the breast (figure 1). This description should include an explanation of Montgomery's Tubercles, the small fleshy globules on the aerola that secrete a substance to keep the nipple and aerola tractile. Mothers should be warned of the possibility of infection if these globules are squeezed or handled roughly.

The 15 to 20 openings at the tip of the nipple through which milk eventually flows should be pointed out to the mother. Invariably, this information relieves the mother who had been under the impression that there was only one opening for the milk.

- An explanation of the internal functioning of the breast. This serves to reassure mothers of their capacity to produce milk. Figure 2 provides a simple explanation of the "reservoir aspect" of the milk supply and establishes that the breasts are always full and ready to feed the baby.

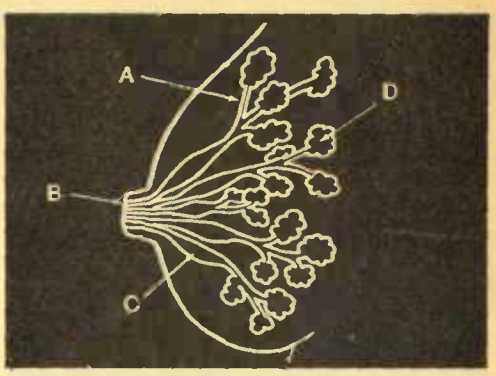


Fig. 2 — cross-section of breast
A lactiferous ducts leading to milk reservoirs
B openings of lactiferous tubules
C ampullae (milk reservoirs)
D alveoli (where milk forms)

Preparatory Exercises

During the third trimester of the pregnancy, the nurse may suggest the following exercises to assist the mother. *Nipple Protrusion Exercises:* roll the nipple between the thumb and the index finger; or stimulate the nipple between the two thumbs in a vertical or horizontal direction, with some stretching action on the areola (figure 3).

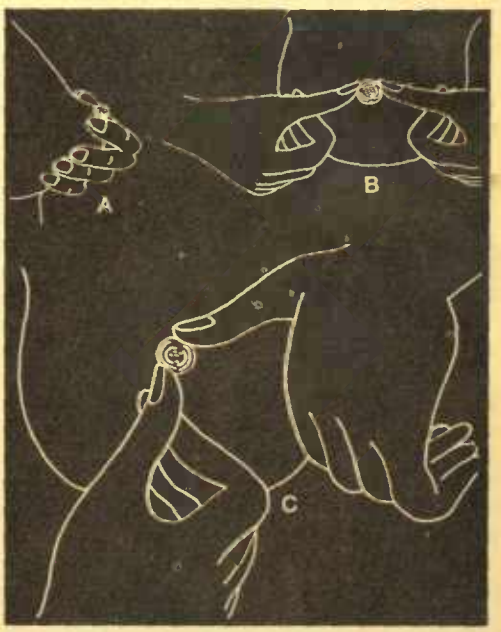


Fig. 3 — nipple protrusion exercises
A stimulation of nipple between thumb and index finger
B stimulation of nipple between two thumbs on an even plane
C pressing areola toward base of the nipple

These exercises are to be done, beginning in the sixth month of pregnancy, at least twice daily.

Massage: The breasts should be massaged and pressed for one or two minutes twice daily, six to eight weeks before delivery (figure 4).

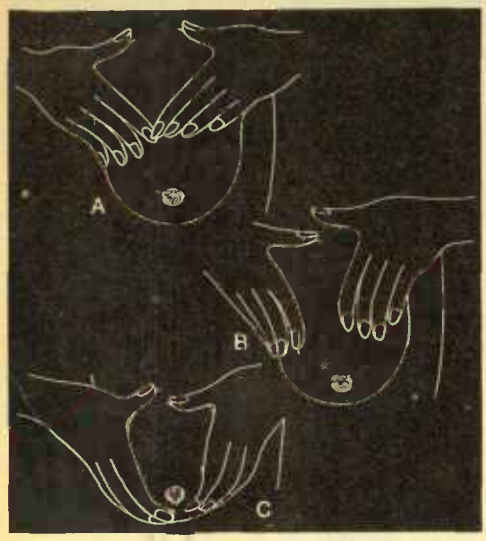


Fig. 4 — breast massage
A starting position
B the hands slide toward the areola while exerting continued pressure
C the hands are cupped around the breast

These two exercises are useful in instructing the mother in emptying the breasts manually, and thus preventing engorgement. They also facilitate a better milk ejection reflex once the mother begins to breast-feed her baby and allow her to become familiar with handling her breasts so that she is more confident postpartum.

II In-Hospital Instruction

This phase completes the information given during the prenatal period and it would be useful to emphasize the following points:

Hygiene

Meticulous washing of the breasts and hands is necessary before each feeding in order to avoid infection. Alcohol and soap should not be used on the breasts since they cause chapping. The nurse should show the breast-feeding mother how to clean her nipples before and after each feeding with sterilized water and absorbent cotton or compresses. Cleaning before each feeding removes any trace of creams that may have been applied earlier. After feeding, cleaning protects the nipple and the areola, for whether they are dry or dripping with milk, they are ideal places for the growth of bacteria.

Position

It is essential that the mother be in a comfortable position. Research has shown that the sitting position is best for efficient draining or emptying of the breasts. If she can, the mother should follow the recommendations given in figure 5. Or, for the first few days following an episiotomy the mother may prefer to breast-feed her baby while lying down(figure 6).



Fig. 5 — nursing in a sitting position
A pillow under the arm supports the baby
B armrest to support the arm
C feet raised for relaxation
D the spine supported against the back of the chair



Fig. 6 — nursing while in a lying position
The mother and child are parallel to each other. The mother's shoulder is on the bed, a pillow supports her head.

Schedule

In general, nurses should place the baby at its mother's breast while still on the delivery table (the baby having at least an Apgar of 8 to 10). This precocious sucking stimulates the secretion of milk, prevents postpartum hemorrhage, and by means of ingestion of colostrum, promotes a better intestinal peristalsis which helps the child to empty the meconium. Another reason for early breast-feeding is that colostrum is less irritating to the esophagus than water and glucose. Colostrum produced during the firs twelve hours following delivery contains a high concentrationof Vitamins A and E, as well as antibodies. During this period, the child should be allowed to nurse whenever it is hungry.

In most hospitals, breast-fed babies are put on the same schedule as those who are bottle-fed, (i.e. q4h). Little consideration is given to the fact that the mother's milk is digested by the baby in two to two-and-one-half hours. If rooming-in is not permitted in the hospital, breast-fed babies should be placed on a three-hourly schedule including night feedings. According to Applebaum's recommendations (1970), the nurse should explain to the mother that during the first day the baby must suck for five minutes on each breast in order to facilitate o promote the milk ejection reflex. On the second day, the feeding time should be ten minutes per breast, and on the third day, fiftee minutes per breast. Total feeding time shoul not exceed thirty minutes. The mother shoul not take hypnotics because these lower her basal metabolism and consequently the secretion and excretion of milk will be reduced

Feeding

Once in the proper position, the mothe needs to be shown how to support and offe her breast to the child by taking the areola an the nipple between the index and the middl fingers in order to project the nipple (figure 7)



Fig. 7 — offering the breast to the infant
The areola is gripped between the index and third fingers to facilitate milk flow from nipple.

She will thus be able to stroke the baby's mouth or cheek so that he turns his head towards the nipple by himself. Never try to tur the baby's head in the desired direction

because he will automatically turn his head towards this touch.

It is important to remind the mother that the nipple and part of the areola must be inside the baby's mouth in order for him to suck properly without injuring the nipple. While the baby is sucking, depending on the shape and size of the breast, the mother will lower it gently with the index finger in order to enable the child to breathe (figure 8).

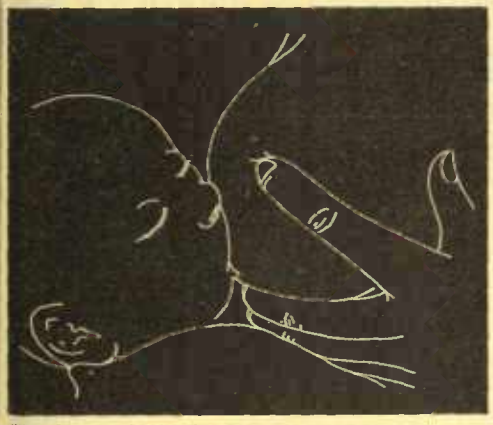


Fig. 8 — to keep the baby's nose free to breathe,
the mother presses her breast lightly with her index finger.

The nurse should try to encourage the mother to be calm and relaxed while breast-feeding her child. She should also be careful to avoid all negative behavior when in the presence of breast-feeding mothers.

When the baby begins to take in less milk, that is to suck with small irregular lunges at the nipple, the nurse will demonstrate to the mother how to use the alternate massage method. She will help her massage one section of the breast after the other in order to soften each region of the breast with her fingers (figure 9), and do so without removing

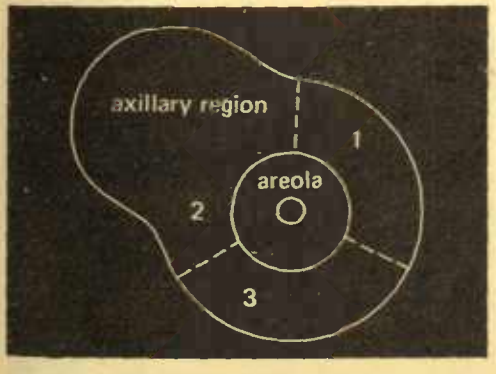


Fig. 9 — breast divided into imaginary quadrants.
The mother massages each quadrant in turn during lactation if the infant has a sluggish sucking reflex.

the baby from the breast. This massaging promotes the draining of the breast and it enables the child to begin to suck more vigorously in the middle of a feeding.

Drainage

In order to avoid engorgement of the breasts and to ensure better drainage, the mother, with the assistance of the nurse, should put into practice the exercises learned during the prenatal period — that is, the manual massaging and pressing of the breasts. This should be done after each feeding as long as the baby does not succeed in sucking for half an hour.

It is the draining of the milk and not its production which is the "sine qua non" of successful breast-feeding. If the mammary gland is not emptied by the baby, excessive milk-induced pressure builds up in the ducts and alveoles of the breast. This results in flattening of the secreting cells of the alveoles and consequently in a significant decrease in milk secretion.

In order to facilitate the milk-ejection mechanism, doctors prescribe ocytocin in the form of nasal spray a few minutes before feeding. The nurse should show the mother how and why this is used.

III At-Home Instruction

The nurse responsible for postnatal classes or for at-home visits (6-8 weeks postpartum) may include the following recommendations in her instructions to breast-feeding mothers:

Drug Use

In general, mothers who breast-feed their babies should not take drugs because, once in the mother's milk, they may have different effects, such as blocking the activity of some enzymes in the baby, interfering with normal physiological functions, or provoking hypersensitivity reactions in the infant. Many factors come into play once drugs are taken: the ionization of substances (PH), their concentration and their administration. The way a drug is administered, for example, is important with respect to the drug's level of concentration in the mother's milk. The level of concentration is always higher when a drug is taken intravenously (Catz and Giacoia, 1972).

Certain drugs should not be taken by breast-feeding mothers: anticoagulants, antithyroid drugs, laxatives, narcotics, bromides, tetracycline and metranidazol (Flagyl). Concentrated alcohols such as cognac and whisky are also to be discouraged.

According to Catz and Giacoia(1972), drugs which are not as yet contraindicated if used in *small* doses are aspirin, insulin, caffeine and cigarettes(not more than four per day). These do not seem to bother the baby.

Schedule

Studies have shown that the baby drinks 90 percent of the milk he needs during the first seven minutes of breast-feeding. No feeding should last longer than 30 minutes. Lactation increases according to the baby's needs. The more he drinks, the more milk is secreted. The ideal situation would be breast-feeding on demand, since this method would be based on the baby's needs. Also, according to Illingworth and Stone (1958), it would help prevent problems such as engorgement of the breasts and cracked and ulcerated nipples.

Most mothers take four weeks to get accustomed to breast-feeding. If demand feeding is too difficult or a source of anxiety, the nurse can suggest a three -hour schedule for the first six weeks of breast-feeding. With this schedule, or even with feeding on demand, it is found that the baby will rarely feed more than six or seven times every 24 hours. Instead, the number of feedings decreases gradually according to the baby's appetite down to four to six feedings per day. Most babies continue to require night feedings until about ten weeks.

Once the mother is at home, she should at first give one breast per feeding in order to completely empty each breast in turn. At the next feeding, she will begin with the other breast. If the baby is very hungry or if he is very small, the mother will continue to give him both breasts on each feeding and will begin the next feeding with the breast offered last during the preceding feeding.

It must be emphasized that the baby must never be given additional or complementary water or milk bottles. The use of a bottle requires less sucking effort. This will weaken the baby's cheek muscles and make him lose the ability to squeeze the breast with his lips, tongue and cheeks. An infant may be fed only at the breast until he is four or even six months old.

Weaning and Solid Foods

Weaning must always be gradual one at a time, breast-feedings are gradually replaced by bottle-feedings. Weaning should normally last three weeks in order to avoid physical discomfort to the mother (engorgement of the breasts). This method has the added advantage of stopping the secretion of milk very gradually.

During the weaning period, the mother should reduce the quantity of liquids she drinks during meals, and wear a good brassiere even

at night in order to avoid sagging of the breasts.

Breast-fed babies double their birth weight by 14 to 16 weeks. Pediatricians favoring breast-feeding introduce solid foods around the third or fourth month, for according to studies such as those conducted by Beal, salivary secretion, which helps the digestion of food, begins only towards the third month. Barkwin in his study states that before they are three months old, babies reject food with their tongue, and it is only towards the third or fourth month that they begin to introduce food in the back of their mouth. With the early introduction of solid foods and cow's milk, the child consumes ten times more salt than he should and thus increases his susceptibility to hypertension later in his adult life. Solid foods recommended towards the third month are mashed ripe bananas, precooked baby cereals enriched with iron, and egg yolk. If the mother breast-feeds her baby up to six months, she may, when weaning, introduce the baby directly to the cup without the use of a bottle.

Infection

Cleanliness of the hands, breasts and brassiere is essential in the prevention of breast infection. Maternal compresses must be changed frequently when wet.

If a mother complains of localized pain or sensitivity of the breast, the nurse may recommend the following:

- doubling the number of feedings from the sore breast in order to drain it more completely (every two hours);
- frequent application of moist hot compresses for a few minutes daily before breastfeeding;
- alternation of breast-feeding postures (sitting and lying down);
- longer rest periods;
- a mild analgesic prescribed by the doctor to relieve the pain and facilitate the milk ejection reflex;
- Do not, under any circumstances, stop breast-feeding.

Diet

Mothers who breast-feed their babies must eat a well-balanced diet, consisting of cooked fresh vegetables, fruits, meat, fish, dairy products and whole grain cereals. The nurse may recommend Canada's Food Guide. Gunther (1955) noted a relationship between the mother's diet and the composition of her milk. For example, an increase in carbohydrates in her diet increases milk secretion, while an excess of lipids/fats decreases it.

Mothers who breast-feed their babies are often thirsty. It is a good idea to recommend that they drink 2,500 ml — 3,000 ml of liquids in order to quench their thirst, increase their milk secretion and stimulate their milk ejection reflex. Too much of some foods such as asparagus, cabbage, onions or rhubarb gives a specific flavor or taste to the milk. Game or wild fowl are not recommended because of the toxins carried by these animals. A balanced diet that is varied and nutritional is the obvious solution. Above all, mothers must not be made anxious by unnecessarily complicated dietetic recommendations.

Activities

It is recommended that the mother avoid fatigue. If possible, she should rest for one hour every afternoon. It is obvious that following delivery a young mother will tire quickly. Her body must regain its balance, and in order to do so she must lead a calm and non strenuous life. A young mother will need at least six weeks before becoming accustomed to her new pace of life.

Birth Control

The contraceptive powers of breast-feeding have been studied by many authors who have arrived at different conclusions. Some, like Gioiosa (1955), Udesky (1950) and Douglas (1950), noted a 95 percent decrease in the incidence of pregnancy among women who breast-fed continuously and intensively until the sixth month following delivery. However, after a symptothermic study of the ovulation mechanism, Pascal (1971) found that with *abundant and prolonged breast-feeding*, the first ovulation never occurs before the sixth week following delivery. From this she concluded that the period of absolute sterility covers only the first five weeks following delivery, provided that the child is only breast-fed. These authors agree that the more additional solids or feeding-bottles are introduced at an earlier date, the higher the incidence of ovulation and pregnancy.

Therefore, given that breast-feeding is not a safe method of birth control, the nurse who gives at-home instruction or postnatal classes may, depending on the wishes of the individual couples, reinstruct them in the various methods of birth control. Methods such as IUD's and condoms may be suggested to couples who wish an alternate method to oral contraceptives. The nurse may recommend IUD's because their rate of spontaneous rejection is lower when inserted eight weeks after delivery , which generally coincides with the postnatal medical examination.

Conclusion

The success of breast-feeding depends on three interdependent variables:

1) parental motivation;
2) a healthy child with a good sucking reflex
3) a competent nurse.

It is the author's hope that this article wil help nurses become more successful with respect to the third variable.

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FREEZING BREAST MILK AT HOME

Denyse Theberge-Rousselet



Photo: La Presse

The consultant on breast-feeding is often called upon to teach mothers how to store and freeze breast milk. Breast-feeding is regaining popularity among new mothers, and they often nurse their babies for a long time. Thus, they need a reserve of frozen breast milk for use during their absences from home.

Following are guidelines for the storing and freezing of breast milk at home:

1 Use jars that are of convenient size for freezing; baby food jars are a good example.

2 Sterilize jars, lids, containers for the milk collection, and breast pump (if used) either by washing them in a dishwasher (one that has a sanitizing cycle or where household water reaches 60° C.), or by boiling them for 3 minutes, after thorough washing.

3 Wash hands thoroughly before expressing milk.

4 Collect milk by manual expression, or by a hand or electric breast pump. A freshly sterilized jar should be used for each milk collection.

5 Refrigerate the milk immediately. Once cold, place it in the freezer. It is recommended to freeze milk that will be used more than 24 hours after expression.

6 When adding freshly expressed milk to a partially filled jar of frozen milk, cool the fresh milk first by placing it in the refrigerator or freezer for a few minutes. This prevents the warm milk from thawing the top layer of frozen milk.

7 Do not fill jars or cap them too tightly when freezing milk, expansion caused by freezing may crack the jars.

8 Mark the dates of collection on the jars. Milk can be kept frozen for 2 to 3 months, and up to 6 months under good freezing conditions.

9 Before thawing the milk, loosen cap slightly, then place jar in a pan of tepid water. Refrigerate the thawed milk until ready to use it. Before feeding the baby, shake the milk as cream rises to the top, leaving thin, bluish skim milk below.

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THE TREATMENT OF MASTITIS IN NURSING MOTHERS



Denyse Théberge-Rousselet

Considerable uncertainty still surrounds the question of the treatment of choice for mastitis (the name generally used to describe any inflammatory process of the breast). Some doctors order a mother suffering from mastitis to wean the baby immediately, or, alternatively, to temporarily refrain from nursing from one or both breasts. Two principal reasons are cited for this advice: 1. the possibility that the baby will be harmed by the transmission of infection or antibiotics prescribed for the mother through the milk supply; 2. the possibility that the infection will heal more slowly if the mother continues to nurse the baby.

Nurses on hospital obstetrical units often receive telephone calls from worried mothers who have encountered this problem on leaving the hospital and returning home. In hospitals where a consultant in maternal feeding is available, these nurses look to her for advice in determining what treatment to recommend. They are upset by these calls and anxious that the controversy be settled so that they can be sure they are recommending the most effective treatment.

Recent studies suggest, for example, that the reasons cited above for either weaning the baby completely or decreasing the number of feedings, are not valid. It has even been proven that the mother will recover more quickly if these restrictions are not imposed and if, in fact, feedings are *increased* rather than discontinued or decreased.

Physiopathology

Mastitis and breast abscesses (these can occur at any time, not only during pregnancy or lactation) are almost always caused by *staphylococcus aureus* originating from the mother's skin or the nasopharynx of the nursing baby.

An important factor in considering the source of the infection is stasis of milk following the let-down reflex or following attempts to suppress lactation.[4] In theory, the ducts distended by the milk provide a favorable environment for bacterial growth.[2]

Symptoms

The first indication of the problem to health personnel occurs when a woman calls the doctor or the nurse and complains of discomfort in the breast. Sometimes this discomfort is accompanied by a low fever.[1] If the woman is breast-feeding her baby and the breast or part of the breast becomes firm, red, swollen, hot or sensitive, mastitis should be suspected.[3] The nurse must be familiar with these symptoms because she will often need to refer the woman to her doctor.

Treatment

Formerly, treatment was conservative and consisted of termination of breast-feeding and a minimum of breast manipulation or pumping of milk. Weaning, however, has never been necessary; *above all, one should never stop breast-feeding.*[1] It is more logical to attempt to reduce stasis of the milk. The most effective method of doing this is to allow the baby to continue to breast-feed.[2,4] The mother should nurse twice as often, but for shorter periods of time, especially from the affected breast.[1,2]

Supplementary treatment includes bed rest,[3,4] good support for the breasts,[4] and hot compresses[2,4] changed every hour, or intermittent cold compresses[2,4] used in combination with an analgesic to alleviate the pain. Antibiotics are sometimes administered.[1,2,3,4] When a general infection of the breast localizes into an abscess, surgical incision and drainage is indicated.[3,4]

Results

Studies done by the four authors cited in this article reveal that the majority of subjects continued to nurse successfully during and after mastitis. No babies were weaned because of mastitis alone.[2] After studying 71 cases, Dr. W.P. Devereux suggests that the implementation of prompt treatment is important in preventing abscesses.[2] Dr. E.Robbins Kimball suggests that an abscess is often prevented without resorting to antibiotics if the woman consults her doctor as soon as symptoms appear.[3]

There is no evidence that any of the babies studied suffered secondary effects as a result of the inflammation.[2,3] This was true even for babies who were breast-fed immediately after incision and drainage of the abscess.

Implementation of this treatment shortened the duration of the disease — often by as much as one-half or one-third. In addition, fewer of these women developed a breast abscess than those who stopped nursing.

Conclusion

When a mother reports symptons of mastitis to the nurse, she must be made aware of the importance of communicating this to her doctor with a view to preventing a more serious infection, or even an abscess.

It is to be hoped, from a nursing standpoint, that most women being treated for mastitis will continue to nurse. This has the advantage of being both the most efficient treatment and also the easiest to initiate. At the same time, it allows the mother to continue feeding her baby in the way she has chosen.

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Photo: Gabor Szilasi

A guide to drug use during breast-feeding

BABIES AT RISK?



Denyse Theberge-Rousselet

In recent years women have increasingly chosen to breast-feed their offspring with the result that a growing number of babies have become the passive recipients of drugs, prescribed or otherwise. To date, however, little research has been done on the presence of drugs in breast milk and their effect on the young recipients. Although it is generally agreed that any substance taken by the lactating mother will, to some extent, be found in her milk, not enough is known of the necessary precautions or the amounts that may have a harmful effect on the baby.

When he has to prescribe drugs to the lactating mother, the doctor must weigh the drug's benefits and the need for the drug against the known and unknown risks to the child. In many cases, risks may be reduced if careful consideration is given to the choice of drug and the explanation given the mother. If possible side effects in the mother and baby are also taken into account, risks are even further reduced.

The nurse who is in contact with mothers who breast-feed their babies must be familiar with types of drugs that may cause problems and are, therefore, to be avoided. She should also know certain principles considered by doctors in prescribing drugs to these women.

Some of these factors include:

1 Type of drug: some drugs are excreted in the mother's milk in greater quantities than others.

2 Dosage: the baby's age as well as the quantity of milk consumed daily must be considered.

3 Duration of drug treatment.

4 Method and timing of administration in relation to the baby's feedings: a smaller quantity of the drug will be found in the milk if medication has been taken immediately after the previous feeding.

5 Cumulative effects of the drug.

6 Development of the baby's organs: immaturity of hepatic and renal functions may decrease the excretion or inactivation of drugs and thus increase the concentration of a drug in the infant's bloodstream.

7 Hypersensitivity of the infant.

8 Possible secondary effects on the mother's behavior, for example, drowsiness.

9 Possible secondary effects on the quantity of milk. Oral contraceptives, for example, are known to influence the milk supply.

Many drugs taken by the mother affect her breast-fed baby. The list that follows is based on the most recent medical literature, but only the most common drugs are mentioned. Information on a variety of less common drugs may be found in the references cited in this article.

Analgesics

These are the most commonly used drugs. Occasional therapeutic doses generally affect neither the quantity of milk produced nor the baby. However, mothers who take large doses for prolonged periods (for example, mothers being treated for rheumatoid arthritis) have not been studied and, consequently, data on these women are not available.[1]

Aspirin appears in the mother's milk in moderate quantities. It may produce a tendency to bleed either by a decrease in the quantity of prothrombin in the baby's blood or by interfering with the function of blood platelets.[2]

Codeine does not significantly affect the baby when taken in therapeutic doses.[3]

Heroin appears in relatively high concentration in the breast milk when the mother is addicted to the drug.[3] Thus, it will prevent withdrawal symptoms in the newborn addict.

Meperidine (Demerol) has an insignificant effect when taken in therapeutic doses.

Morphine has little effect when taken in therapeutic doses.[3] However, it is found in sufficient concentration in the milk of an addicted mother to prevent withdrawal symptoms in the breast-fed infant.

Nisentil has a sedative effect on the infant when taken in therapeutic doses.

Darvon has little effect on the baby when taken in therapeutic doses.[3]

Antacids

These drugs are rarely absorbed in appreciable amounts and should present no problem unless the mother develops an electrolytic imbalance.

Anticarcinogenic Drugs

These drugs may inhibit formation of bone marrow in the baby. They should be a contraindication to breast-feeding.[2] Antimetabolites (methotrexate, mercaptopurine) may be secreted in the milk and breast-feeding should be avoided.

Anticoagulants

Oral anticoagulants should be avoided because they have not been sufficiently studied. They have been reported as causing severe bleeding in the infant.[2,4] For other anticoagulants, both mother and baby must be watched very carefully in order to avoid hematomes and hemmorhage in the baby.

Antihistamines

These drugs are often taken to alleviate colds and allergies. They generally reduce the production of milk, but this is not always noticeable if the drug is taken intermittently and in small quantities. They lead to vasoconstriction in the mother and limit the quantity of oxytocin reaching the breasts. The decrease in milk supply may be minimized if the mother's intake of fluids is greatly increased. Benadryl has a more marked effect than Chlor-Tripolon which, of the whole group, has least effect on the production of milk.

Antimicrobial Agents and Antibiotics

Studies have shown that these drugs pass into the mother's milk in small concentrations. In addition, the presence of these substances in the mother's milk may alter the baby's intestinal flora; normal intestinal flora are important in the early development of immunities.[1,2,3]

Ampicillin is secreted in milk and may cause allergy and/or diarrhea.

What are the known and unknown effects on the breast-fed baby of drugs consumed by the nursing mother?



Chloromycetin may cause the "gray syndrome" in the newborn and may also damage the bone marrow.[2]

Erythromycin, although secreted in milk, may be used, but may cause allergy to the drug.

Kanamycin requires the baby to be watched carefully for signs of toxicity.[4]

Penicillin is secreted in milk, but may be used. However kernicterus may develop in the newborn.

Streptomycin is secreted in milk. It may be used but may cause toxicity.[5]

Sulfonamides may cause kernicterus in the newborn[3] and also hemolytic anemia.[2] Sulfapyridine has caused cutaneous eruptions.[4]

Sulfathiazole may be used in therapeutic doses.[4]

Gantrisin may cause kernicterus in the newborn and should be avoided during the first two weeks postpartum.[4]

Tetracyclines may cause dental stains in the baby and retard bone growth.[2]

Oral Contraceptives

Recent research seems to indicate that smaller doses of oral contraceptives do not significantly affect lactation in the majority of women, once the supply of milk is well established (6-8 weeks). If the mother has initial difficulty in establishing a good milk supply for her baby, even small doses of oral contraceptives may add to her problems.

Large doses of oral contraceptives suppress lactation and even usual doses can decrease the milk supply. The immediate and long-term effects of oral contraceptives on the baby are not known. *Other methods of contraception should therefore be encouraged during the entire period of lactation.*[5]

Corticosteroids

These appear in milk and may hinder growth, interfere with the endogenous production of corticosteroids, or cause other undesirable effects. Breast-feeding should be discouraged.[2]

Diuretics

These drugs should be used with caution during breast-feeding. No secondary effects have been reported in the literature cited here, but diuretics seem to inhibit lactation by dehydrating the woman. Diuril may cause thrombocytopenia in the baby.[2]

Hyponotics and Tranquilizers

Several sleep-inducing drugs contain bromides. Such drugs should not be taken as the baby's reaction to them may vary from cutaneous eruptions to drowsiness.[3]

Chlordiazepoxide (Librium) may be used in therapeutic doses.[5]

Chloral hydrate may have some sedative effect on the baby, but may be used in therapeutic doses.[3 4]

Chlorpromazine is secreted in the mother's milk but no effect was found in babies even with large doses. It may cause galactorrhea.[5]

Diazepam (Valium) in large doses sedates the baby.[2] It may cause hyperbilirubinemia and its use is not recommended during lactation.[5]

Meprobamate (Miltown, Equanil) requires that the baby be watched carefully for signs of toxicity.[5]

Phenobarbital has a sedative effect on babies with hypnotic doses of 100 mg. It is possible that there is no effect with sedative doses (30 mg t.i.d.).[2] It may also affect the endogenous production of corticosteroids in the baby or have other undesirable effects.[1 2]

Secobarbital Sodium (Seconal) has no effect on the baby with sedative doses; however, there may be some effect with hypnotic doses.

Laxatives

The forms that are not absorbed, such as castor oil, Dulcolax, mineral oil, and standardized senna concentrate (DSS) do not cause any problems.

Cascara causes increased intestinal activity in the baby with habitual doses.

Rhubarb has no ill effects when taken in small quantities but large doses increase intestinal activity in the baby.

Senokot and *Doxidan* can cause loose stools in a baby.

Drugs Affecting Endocrine Glands

Thyroid preparations are not harmful to the baby when the mother takes them in habitual doses. It is believed that they sometimes increase the amount of milk produced.

Radioiodine is passed into the mother's milk in large quantities and may significantly suppress thyroid function in the baby.[3]

Propylthiouracil and *thiouracil*[3 5] have effects similar to radioiodine. However concentrations of thiouracil in the mother's milk are higher than in the urine or blood and may cause goiter in the baby or agranulocytosis.[4]

Drugs Affecting the Autonomic Nervous System

Atropine may reduce the amount of milk produced when large doses are taken; it is not secreted in appreciable amounts in the milk. It may cause atropine poisoning in the baby.[2 3]

Ergot (Cafergot) may cause various symptoms in the baby, from vomiting and diarrhea to a weak pulse and unstable blood pressure.[3 4]

Other Agents

Stimulants, depressants, narcotics, and psychedelics have not been studied in relation to breast-feeding. They are believed to be secreted in the milk in appreciable quantities and should not be used.

Alcohol if used moderately, has no harmful effect on the baby. Large quantities may cause sedation in the baby or inhibit the milk secreting reflex in the mother.[2 3 5 6]

Certain foods have been found to cause allergic reactions in the baby: white beans, Indian corn, egg white, chocolate, seafood, peanuts, wheat, and gherkins.[3]

Methadone is not passed in significant quantities to the breast-fed baby whose mother takes a daily dose of this drug.

Tobacco (nicotine) affects the baby if the mother smokes heavily. Effects may vary from diarrhea, vomiting, and tachycardia to agitation.[5]

Vitamins that are fat soluble must not be taken in large doses. One study reported anomalies in the baby when the mother had taken large doses of Vitamin D during pregnancy. Vitamin D may also cause hypercalcemia.[4 7]

Conclusion

Because so many factors are involved in choosing drugs for the lactating mother, and because so little conclusive research has been done in this area, it is difficult for the doctor to advise the mother. *In general, the best advice would seem to be to avoid the use of drugs if at all possible.*

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MATTHEW MY SON:

. . . "I never did meet a nurse on the obstetrics ward who had children . . . I had no idea what kind of care to expect as a patient, or what was



Reprinted with permission from the McGill Medical Journal, Fall, 1975. Illustration: K. Kiley

Prepared childbirth at the General

Beverly MacLellan

The promise: On the day that I gave to my first child, my husband wrote an exam for a McGill Faculty of Medicine course in human growth and development. During that course, the return to more "natural" methods of childbirth and infant care — breast-feeding in particular — was enthusiastically praised as logical, scientifically superior and . . . well, natural.

There was no need to convince my husband — he and I were already enrolled in a prepared childbirth training program — but I found it encouraging that the sentiments of the faculty staffing the hospital where I was to have my baby were in accord with our own.

The prepared childbirth program includes much the same material covered in my husband's school course, he said, but also a great deal more. Its purpose goes far beyond simply teaching a little physiology. The main idea is to take the surprise and uncertainty out of childbirth by teaching you in advance everything that is going to happen, everything that you will see and feel both physically and emotionally.

You visit the labor room ahead of time, and you see pictures of the room in which you're going to have your baby. You know the beds, the chairs, the clock on the delivery room wall before you arrive. The frightening array of machines and instruments have all been explained, demonstrated and demythified and are now almost old friends.

You know the mental states you're going to go through: the exhilaration, the despair, the depression. And in the end, you go through them all, just like stops on a train.

You gain greater control over your body with a series of exercises so that you can forego drugs during delivery and thereby participate more fully and lucidly in bringing your child into the world. No amount of exercise can offer you delivery without pain, but you learn to deal with the pain. You practice dissociating yourself from it, to look at it from a distance. You try and keep one part of your body separate from another, so that when there is tension in one part, or pain, the rest of your body can be calm and relaxed.

It's all hard to believe, but you feel yourself getting better and better as the days go on. Through it all, your husband is the coach, the trainer, the man who knows your capabilities almost as well as you do. During the delivery, he will be at your side.

When the time came to go to the hospital, we felt we were ready.

The practice: Everything began rather well. When my doctor announced to those in the case room that we were "a prepared childbirth family" there was only a second's pause to look us over — and then a helpful flow of encouragement and strength that continued throughout the delivery. Good news.

The bad news was that I was having a back labor — occiput posterior — and that all the labor training exercises we had done every day for months were largely for naught. As I had learned in our course, the pattern of contractions in a back labor is so unusual and prolonged that it is very difficult to anticipate them and remain in control. It was, in the end, simply a case of "doing the best you can." After six hours of the best that my husband Keith and I could muster — and some deft mid-delivery forceps work by the obstetrician — son Matthew was born.

After it was over, I lay awake in my room, staring at the ceiling, overcome. After nine months, emptiness. Keith was gone, off writing his exam, Matthew was gone, my stomach was gone, my last bit of energy — all gone. I was empty.

And I was full to bursting. The totality of the experience was overwhelming and I longed to talk about it with someone who could understand. "Do you have any children?" I asked the nurse. But she shook her head. I never did meet a nurse on the obstetrics ward who had.

In the end, I just tried to adjust to the routine day of those around me. I quickly found out that there was something my study hadn't prepared me for. I knew I was to expect

expected of me . . . What I did find justifiably distressing, however, was the state of the nurses' knowledge about breast-feeding."

discomfort at first, and fatigue, and perhaps depression. But I was dismayed to realize how completely helpless I was.

When breakfast came, because of the discomfort of the episiotomy, I found it impossible to sit, or for that matter to move most of my body at all. I finally ate lying down, feeling foolish, but I couldn't think of a better way.

Then, breakfast over, I waited for someone — anyone — to come. Several hours had elapsed since the delivery, but I had not had a chance to wash myself or change my clothes, and it was clear that I wouldn't be able to do these things alone. My purse lay out of reach; other things I needed were in the closet. I hated my dependency.

So I had to face the question of the bell. It had taken me the better part of the morning to figure out what it was when I had first found it. Now I was quite hesitant about using it. I assumed the staff functioned as a matter of course. My requests certainly seemed routine; perhaps the light was for emergencies only. I had no idea what kind of care to expect as a patient, or what was expected of me. Perhaps they were understaffed. Perhaps they forgot. I pulled the cord.

A little later a phone call beckoned me to come and feed my son. I asked if he could be brought to me, just as I saw happening to mothers all around me. "Impossible," the woman on the other end assured me, as Matthew was in intensive care.

Intensive care: Up until that time I had no idea that anything was wrong. I got someone to wheel me there as quickly as I could, but my mental state was in a shambles when I arrived.

The nurse now explained that Matthew was fine, that he was only in intensive care awaiting a *pro forma* checkup by a pediatrician because forceps had been used during the delivery. Finally, and with great relief, I saw my son for the second time.

As I fed him, I began to fear that, after a successful delivery, things in the hospital were not going to go according to plan. During the next four days they never picked up much. Partly because I was sore and tired, I think, but also because, in contrast to the smooth teamwork of the case room, the ward doesn't really have it all together. Whatever the professors teach in their courses, the ward is not really geared to mothers who want to breast-feed and have their babies live in.

Ideally, I would have liked to keep Matthew in my room at all times except for visiting hours, but this proved impossible. He didn't stay all night until the last because of my lack of physical mobility, but our crackingly efficient nurse made it difficult to keep him in the room just for the evening. She had very definite ideas, most of them about germs, and for this reason, I think, she disapproved of rooming in. She also disapproved of my husband for much the same reasons, I guess, after she discovered him on the bed one day surrounded by the Sunday paper.

The first time I tried to take visitors to see Matthew I found out that when he wasn't in my room, he wasn't in the nursery either. He was kept in another little room by himself, apparently because of the contamination of rooming in. Fair enough, I respect the hospital's concern about germs and about possible contamination from the outside, but it did seem a little hollow when I discovered one of the professors teaching a class of sixteen students in the nursery itself.

What I did find justifiably distressing, however, was the state of the nurses' knowledge about breast-feeding. I had read several books on this practically forgotten art before coming to the hospital, and spoken to several women who had successfully breast-fed their children, but I supposed a nurse must know what an infant's nutritional requirements were, and how the lactating breast best functioned. Surely, I thought, all this would be a part of every nurse's education. But I guess they all went to different schools.

My day nurse insisted that, in addition to breast milk, Matthew needed formula; my night nurse was an avid believer in glucose and water; and the apparition that bore him to me at two in the morning assured me he didn't need any supplement.

There appeared to be a consensus on one point only: nursing should be limited to three minutes at each breast to begin with, and the time slowly increased over a period of days. This is apparently a hospital policy designed to prevent sore nipples, based upon the assumption — usually accurate — that most North American women will not have prepared their breasts for nursing in advance. Unfortunately, according to what I read, and confirmed, it seems, by my own experience, this seems to be bad physiology.

It apparently takes about three minutes of sucking before the "let down" reflex makes milk available at the nipples — oxytocin and all that. So after inadequately short spells of nursing, the child either goes away hungry, or is given a topping up of glucose and water.

But this, I am told, is the start of a vicious circle. Unlike the breast, the bottle requires little sucking before it delivers its milk. The liquid flows easily into the baby's mouth. His cheek muscles weaken and his desire to nurse diminishes. Poor sucking leads, in turn, to poor milk production and letdown, and finally to milk tension and engorgement.

As the breast tissue swells, the infant can grasp only the nipple instead of the areola, and the chewed nipple becomes very painful. All this seems to exacerbate the psychological factors that influence milk let down — anxiety, fatigue, and pain.

The point is that *I knew* the mechanisms they were suggesting were wrong. I had the advantage over most mothers. I had been warned. But it didn't matter. When the time came, I was in no position or shape to resist, and I began to doubt. I thought they really must know. I fumbled through each nurse's regimen in turn, and the predictable result was painfully engorged breasts and a very poor start at breast-feeding.

I can only speak from my own experience. Perhaps I was destined to have trouble initially with breast-feeding. But it does seem that the obstetrics ward could be a positive educational force rather than an added source of confusion on the subject.

As I think back now, I'm very pleased I had the training in prepared childbirth. I don't think the delivery could have been so successful without it. They had promised me no surprises and there had been none. Still, I realize now that the words don't exist that could really prepare you for such an overwhelming experience.

And as for life on the obstetrics ward — well, it's clear my training was no match for that. I don't know if any really could be.

Finally, the fourth day and check out time arrived. I was convinced that things would be better at home — as they eventually proved to be — and I was anxious to leave. My husband put Matthew in my arms and we started down the hall slowly, still doing the postpartum shuffle. It was feeding time, and we passed the women standing like sentinels in the doorways, waiting for their babies.

". . . Bow down to her on Sundays, salute her when her birthday comes . . ."

My thoughts were interrupted by two nurses, who anxiously asked where we were going.

"Home," I said, rather defensively.

Not without having our name tags officially cut, we weren't. Finally, we walked down the corridor toward home. As we approached the door, the cleaning woman who had been standing watching us, mop in hand, shook her head. As she resumed mopping she said, "If I was you and that was my baby, I wouldn't have no one telling *me* what to do."

Indeed.

Beverly MacLellan is a Montreal artist, mother, and wife.

SHAPING A NEW FUTURE

Bernadet Ratsoy

Traditionally, responsibility for health care planning has rested with administrative personnel and/or physicians. Today many nurses, already pressing for wider recognition and responsibilities in other areas, are beginning to feel their expertise has been ignored too long, and are insisting on being included in health care planning councils.

Nurses are in a unique position to contribute to health care planning. They implement and maintain health programs and their work is greatly affected by the efficiency and effectiveness of the facilities. They have close and extended contact with the consumers of existing health services and are aware of those persons who fall between the grids of the health care network. Because their work brings them close to the pulse of the community, nurses often have good ideas about the services needed. What they too often lack are confidence in their ideas and a strategy to follow in getting them accepted and implemented.

To assist other nurses who want to become involved in health care planning, I would like to share my experience in the creation of a family-centered maternity care program and outline some characteristics I have found helpful.

The Evolution of an Idea

Years of nursing practice viewing what I regarded as inadequate assistance to parents, a growing awareness of the potential damage to parents and infants from separation, the apparent demise of the family in our society, and a flood of other thoughts concerning children and their parents, gradually brought me closer and closer to a personal necessity to do something about it where I could. I stress *me* because the need had to become a part of me in order to commit myself to its fulfillment.

A friend and I were instructors in the hospital school of nursing when we began our strategy. We lobbied, we talked and talked to anyone we thought would be helpful in our venture. We tried our ideas on everyone who would listen, never mentioning a program until much later. Initially we were received with, "Oh those pie-in-the-sky instructors who don't realize the realities of the situation."

After a while my colleague's career took a new direction and I was left to continue reading, attending meetings of childbirth education groups, etc., and evolving my arguments.

The final catalyst to action for me was a university experience which gave me confidence in the caliber of my ideas, and an expanded view of health care beyond the nursing unit in which I had worked.

After receiving my university degree I became a nursing coordinator. This move from education to service put me in a position to take advantage of specific incidents to indicate the good sense and humanity of a family-centered maternity care program; also I had a degree of power to implement change.

To create a receptive climate for my program, I provided articles to anyone who showed an interest. I tried to provide the kind of material that would impress most, e.g. articles written by doctors for doctors, studies of hospital stay for administrators, etc. This was difficult, however, because so little had actually been written about such programs. I used material from other disciplines as evidence to support my ideas.

Finally, I wrote a brief presenting my proposal for a better maternity care program. I gave background references and outlined, to the best of my ability, the implementation of such a program. I found it necessary to express myself in writing since no one with the power to do so will commit themselves or the

hospital to an idea on the basis of a verbal argument. In my hospital, as in most cases, the final decisions rest with upper levels of administration. I was the instigator, then the implementor, but not the decision maker. The brief allowed considered thought about my proposal for change, but it also allowed me to demonstrate my grasp of the situation.

Once the decision in favor of a family-centered maternity care program was taken, further planning, with consultation, and implementation were left to me.

The Nurse Planner

When I thought about it later, I realized that my success was not the result of any secret formula, but rather the result of a combination of characteristics and strategy that any nurse could use to sell her own ideas for change. Some words that describe a nurse who plans health programs and succeeds in her strategy are: knowledgeable, dissatisfied, opportunistic, energetic, manipulative (a strategist), patient, repetitious and practical.

First, if you are not knowledgeable about the area you choose to change, *no one*, no administrator, no doctor and no nurse will listen to you. Becoming knowledgeable and establishing credibility as a respected practitioner of nursing is a long process. People don't accept ideas without good evidence, and *you* must provide that evidence.

Establish yourself as a thinker, a reader, forward-looking and knowledgeable about your area of responsibility and understanding of other points of view. Do a PR job!

In many cases, it is dissatisfaction that is the ultimate key to success, because dissatisfaction can be the driving force toward greater knowledge and the personal necessity to effect a change. I believe that the extent of dissatisfaction in an individual is the basis for how much energy he or she is willing to expend in pursuit of an ideal. And you need energy to carry you through the delays and setbacks you will inevitably encounter!

When you are dissatisfied enough about something to try to change it, and knowledgeable enough that others will listen, you then have to incorporate other characteristics. Plan your strategy. Even before talking new programs, talk about new ideas. Lay the groundwork, provide readings, make and propose small changes that are not threatening and easily absorbed but will lead to the ultimate objective. Gear inservice education toward dispensing your own brand of propaganda.

Bring your idea to the attention of those who can be of assistance, and take advantage of every opportunity to press your case. But don't be a bore about it! Be a hummingbird, not a wasp. Understand the motivating forces of those you are trying to convince, and show them the advantages in the proposal.

No matter how well you present your ideas, be prepared for criticism and opposition. Too many nurses are inclined to think that their ideas are self-evident, and respond in an emotional way to opposition. Ideas for change can be timely or they can be ahead of their time. Be patient with those who don't understand or don't want to understand. Remember, bureaucracies take time to change. People, including hospital administrators, need time to think about your proposal. Use the time constructively. Polish your arguments. Don't despair, a year's delay is not the end of the world. I was working in a receptive environment, and in my case it only took five years. Your responsibility is not to let the idea die in the interim.

Don't ever believe you will have a cadre of willing followers who will do the work. You will do the work!

When your idea has been accepted and you are working toward implementing it, seek out others who have the same philosophy to help keep the idea alive. Remember, your idea is not perfect. Someone will come along who will say, "Why are we doing this?" or "Why can't we change that?" The value of your program increases when it grows and receives new input.

Summary

In conclusion, I see my role as a patient advocate, saying and doing the things the patient would do himself if he were able or had the knowledge to do so. Sound familiar? Interesting that Virginia Henderson's definition of nursing has crept into this discussion of health care planning.

In the advocate role, I attempt to translate needs and human considerations into a safe, humane program that can be considered by those who have the power to change existing services. I am constantly concerned about improvements in maternity care, not only in my hospital but in the community as well, and am assessing where I will contribute my efforts. It becomes a way of life: volunteer, initiate, gain attention, and create. Try it!

Bernadet Ratsoy (R.N., Edmonton General Hospital; B.Sc.N., University of British Columbia) is Maternal Child Health Coordinator at St. Paul's Hospital in Vancouver, and a member of the Health Care Planning Committee of the Registered Nurses' Association of British Columbia. The committee's prime objective is to assist B.C. nurses to become involved in health care planning. The above article was adapted from a speech given at the RNABC annual meeting in May, 1975.

YOUR CNA NEXT CONVENTION

Plenty of room for you and your family!

The leading convention center in the Atlantic provinces, the Hotel Nova Scotian, is the site of this year's CNA convention. The Nova Scotian features luxurious lounges, dining spots, shops and a beauty parlor within the hotel, in addition to comfortable rooms, many of which have a sea view. The sessions will be held in the Commonwealth Room.

The "Greetings" Committee will meet planes and trains, wearing their yellow "Sou' Westers" or Evangeline Caps if they're bilingual, ready to welcome and help delegates. There will be information desks at the airport and the hotels, with both English-and French-speaking personnel.

The RNANS Hospitality Committee has arranged for a pipe band to greet delegates arriving at the Nova Scotian on Sunday to register for the convention. Space has also been booked at three other Halifax hotels, as well as at St. Mary's University. Chateau Halifax at Scotia Square, is one of the city's newest and most prestigious hotels where shopping is just an elevator ride away. There's an indoor-outdoor swimming pool and the well-known Noon Watch/Night Watch restaurant offers a breathtaking view by day or night. The Lord Nelson overlooks the beautiful Public Gardens with seventeen acres of lawns, flowers, trees and a lake. It is also in a convenient location close to the shops and fine restaurants on Spring Garden Road.

The Holiday Inn, just completed last year, faces the green Commons toward Citadel Hill. In addition to the coffee shop and dining room, there is also an indoor swimming pool and a popular nightclub.

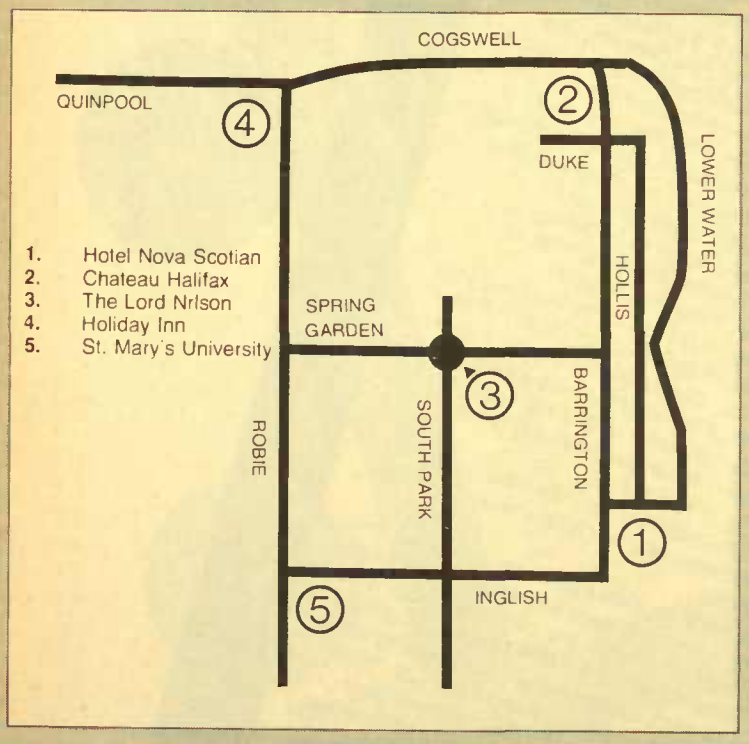
St. Mary's University offers accommodation for both families and singles. *Apartments* consist of two bedrooms, kitchen, living room and bath and shower facilities. Each bedroom is furnished with two single beds, two desks, shelves, drawers, and closet. All linens are supplied but dishes and kitchen utensils are not. There's no charge to put your children on air mattresses, if you run out of bed space. Cribs are available at a small rental charge.

Apartments

Rates	
One day	$30
Two days	$60
Three days	$90
Four days	$110
Five days	$125
One week	$135

Suites are divided into double and single rooms. Each room is furnished with beds, desks, shelves, drawers and closet space. Linens are supplied. Bath and shower facilities are provided for each suite. There are no kitchen facilities, but meals are available in the residence cafeteria on an "à la carte" or meal plan basis.

Rates	Single	Double or twin beds
Hotel Nova Scotian	$31	$36
Chateau Halifax	$27	$33
The Lord Nelson	$20-$28	$24-$34
Holiday Inn	$30	$37





Ralph Nader



W.O. Mitchell

There's an indoor swimming pool, mini-market, art gallery, and the famed Burke-Caffney Observatory where on a clear night you really can see forever! St. Mary's is located in the beautiful south end of Halifax, only 10 minutes from the business and shopping districts.

On receipt of your pre-registration coupon and cheque, you will be sent a hotel reservation card, an admission card and convention kit ticket, a receipt and details on procedure for registration.

Transportation will be provided to and from the convention site and hotel, but participants in the convention must make their own travel arrangements to Halifax.

It's a good idea to pre-register!

Because of the interest expressed in the theme of the CNA Convention and the popularity of the speakers who will be appearing, the convention coordinators strongly advise that you *pre-register* with the accompanying coupon, in order to avoid unnecessary delays. On-the-spot registration will begin Sunday, June 20, at noon.

Further information concerning speakers will appear in future issues of *The Canadian Nurse.*

Suites

Rates	Daily	2 days	3 days	4 days	5 days	weekly
Single	$9	$18	$27	$33	$40	$45
Double	$15	$30	$45	$55	$65	$70

Stopover at the CPHA Convention!

"Changing roles in community health" is the theme of the 67th Annual Convention of the Canadian Public Health Association, to be held June 22-25 in Moncton, New Brunswick (immediately following the CNA meeting).

The format of this convention is designed to involve the delegates through panels and group discussions. The topics chosen for the scientific sessions are:
a) assessment of existing programs;
b) new members and new roles in community health;
c) changing modes of delivery;
d) changes required in outlook. It is not necessary to be a member of CPHA to take part in these sessions.

The convention will be held at the Beausejour Hotel and the University of Moncton. For more information, contact CPHA, 55 Parkdale Avenue, Ottawa, Ontario K1Y 1E5, tel. (613) 725-3769.

Ralph Nader and W.O. Mitchell to appear at CNA convention!

At press time, CNA received confirmation that both Ralph Nader and W.O. Mitchell will take part in the 1976 CNA convention in Halifax this June. Nader, who is internationally recognized as an ardent defender of consumer rights, will address convention delegates in the Commonwealth room of the Hotel Nova Scotian on Monday morning, June 21, at 9:00 a.m. Following this address, he will participate in an open forum for all CNA delegates.

Mitchell is a well-known Canadian author whose books include Who Has Seen the Wind *and* The Vanishing Point. *He is scheduled to speak following the opening ceremonies on Sunday night June 20th.*

Please register me for:
Annual Meeting, Canadian Nurses' Association
Hotel Nova Scotian, Halifax, N.S., June 20-23 1976 and mail receipt, admission card with convention kit ticket, details on procedure for registration and hotel reservation card.

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Registration fees	Total meeting	Daily rate	Specify days
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Names and Faces

Lecturers appointed to the faculty of the school of nursing, Lakehead University, Thunder Bay, Ontario, include: **Elizabeth Marie Clarke** (R.N., St. John's General Hospital school of nursing, St. John's; B.Sc.N., Lakehead University) who has nursed at the Oshawa General Hospital, the McKellar Hospital and Port Arthur General Hospital in Thunder Bay; **Joanne St. Germain** (R.N., St. Joseph's school of nursing, Thunder Bay; B.Sc.N., Lakehead University) who has been a staff nurse at St. Joseph's General Hospital, Thunder Bay; and **Frances Marie Welch** (B.Sc.N., Lakehead University) whose most recent appointment has been that of lecturer at McMaster University school of nursing, Hamilton, and who is currently working toward a master's degree in education.



Jannice E. Moore (B.Sc.N., University of Saskatchewan) has won the 1975 Canadian Liquid Air Ltd. award of $1,000. She was the top student in the first year of the University of Alberta's health services administration program during the academic year 1974/75.

Lorraine Dawson (R.N., University of Alberta Hospital school of nursing; B.Sc.N., University of Toronto) has been appointed to the employment relations staff of the Registered Nurses' Association of Ontario. Her career includes positions in hospital nursing service and staff development. She also brings to her new position experience in collective bargaining both as a member of a nurses' association and as a supervisor.

Lorraine Mills(R.N., Hotel Dieu school of nursing, Edmundston, N.B.; B.Sc.N., University of Ottawa; M.A., Columbia University, New York) has been named associate executive director, patient care services, at the Dr. Everett Chalmers Hospital, Fredericton. She has worked as a head nurse, operating room nurse, supervisor, inservice coordinator, and director of nursing in hospitals in Canada, the United States, and France. Prior to her current position, she was a nursing consultant with the New Brunswick department of health.

Yvette Loiselle of Montreal has become the first woman to be appointed Deputy Chief Commissioner for the St. John Ambulance Brigade in Canada. She will assist the Chief Commissioner, Dr. Al Harrop of Winnipeg, in his duties as head of the close to 13,000 St. John Ambulance Brigade members throughout the country.

Loiselle is an administrative officer with Celanese Canada Limited and is well known in the Montreal business world as an expert in administrative and employee relations matters.

Her association with St. John Ambulance began in 1944 when she joined the Brigade as a nursing member. She advanced to serve as Divisional Superintendent and in 1959 became Provincial Superintendent (Nursing) of the Brigade in Quebec. In 1972 she was appointed Chief Superintendent and assumed responsibility for the general organization, administration, efficiency and discipline of all St. John nursing members in Canada.

Jean Back of London, Ontario succeeds Loiselle as Chief Superintendent. Back was involved with St. John Ambulance during the war in her native England. Her association with St. John continued on her arrival in Canada where she has held various positions within St. John. In 1952 she was admitted to the Order as a Serving Sister. In 1953 she led the Canadian Cadet contingent to the Commonwealth St. John Cadet Camp in England for the celebration of Queen Elizabeth's coronation. She was promoted to Officer in 1955, Commander in 1966, and Dame of Grace in 1972.



Carrol Ann Hartin, (R.N., Brockville General Hospital regional school of nursing) has accepted a two-year tour of duty in Honduras with MEDICO, a service of CARE. Prior to joining the MEDICO team based at the 186-bed Hospital del Sur in Choluteca, Hartin spent six weeks in Guatemala studying Spanish. She will instruct classes in obstetrics for Honduran auxiliary nurses in a hospital school which was established by MEDICO. She has worked in the obstetrical unit at Lady Minto Hospital in Cochrane, Ontario and in the burn unit, pediatrics, at the Hospital for Sick Children in Toronto.

Ann Taylor has been appointed assistant executive director of the Registered Nurses' Association of British Columbia. She was formerly director of public health nursing of the Borough of East York Health Unit in Toronto, prior to which she was executive assistant to the director of nursing at the Vancouver General Hospital.

George Feilotter was recently named administrator of the Cornwall General Hospital. He joined the teaching staff of the hospital's school of nursing in 1965, shortly after which he became assistant director of nursing services. In 1968 he became director of nursing, and a year later, assistant administrator.

Following his basic nursing education, Feilotter studied nursing at the Manitoba Rehabilitation Centre, earned a B.Sc.N. in nursing education from the University of Ottawa, and completed the hospital organization and management course from the Canadian Hospital Association.

The Hospital for Sick Children Foundation, Toronto, has awarded nearly half a million in grants and fellowships. **June Kikuchi,** R.N.,M.N., has been granted $27,000 to study for 3 years at the University of Pittsburgh. She is to work at a doctoral level in the area of nursing care of children.

Monique Foisy has been appointed public relations officer with the Order of Nurses of Quebec. Her nursing career has included emergency care, research, and intensive care; and she has been on staff at the LaSalle General Hospital and the Montreal General Hospital.

Foisy earned her nursing diploma at Hôtel Dieu in Montreal and a certificate in public relations at the University of Montreal. She is currently working toward a degree in public relations.



L'Ecole des Infirmières de Bathurst School of Nursing, Bathurst, N.B., will offer a nonintegrated bilingual nursing diploma program, with classes scheduled to commence in September, 1976. In effect, two programs, one in French and one in English, will be offered.

Constance Morrison, (R.N., Hôtel Dieu Saint Joseph school of nursing, Bathurst, N.B.; B.Sc.N., University of Moncton) has been appointed Director. She has had experience as a general duty nurse, head nurse, supervisor, and private duty nurse. In 1965, she became associate director of the Hôtel-Dieu Saint Joseph school of nursing, Bathurst, N.B., and was its director from 1968 until its closure in 1975.



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What's New



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Vernitron Medical Products, Inc., has introduced the new Model #1810 Sorenson Mobile Aspirator.

The unit is equipped with the patented Visi-Dome Lubrication System that guards against pump damage from inadequate oil supply, and with an airvent overflow cut-off that protects against pump damage through flooding. It has additional features: enclosed motor and pump to control noise factors and assure dust-free operation; vibration-free motor mounts; vane type pump; visible oil supply; visible dial gauge flush-sunk into front panel; and hospital-grade safety plug and built-in cord storage.

For information, write: Vernitron Medical Products, Inc., 5 Empire Blvd., Carlstadt, New Jersey, 07072, U.S.A.

Face Masks

Two lightweight masks to protect against cold air and pollen inhalation have been introduced by 3M Canada Limited.

The 3M Air Warming Mask provides protection against inhaling cold, dry air and remains easy to breathe through and comfortable. When tested at sub-zero temperatures (minus 29°C) the mask warmed and moistened the air to at least 16°C and 90 percent humidity. It is reusable.

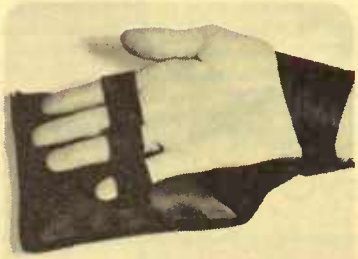
The disposable 3M Pollen Mask protects against pollens that can cause hay fever and helps keep allergens and dust from nasal passages.

For information, write: Consumer Products Division, 3M Canada Limited, Box 5757, London, Ontario, N6A 4T1.

Hot/Cold Food Cart Brochure

Crimsco, Inc., manufacturers of airline and health care dietary equipment systems, announces a colorful, illustrated brochure, "Model ER, Meals-on-wheels, Hot and Cold Food Carts," which deals with the versatility and economics of employing the ER Hot and Cold Food Cart in hospitals and nursing homes. It describes how to convert to a central patient tray assembly system in existing kitchen space and use as few as 3 persons to perform all patient tray assembly operations.

For further information, write: Crimsco, Inc., 5001 East 59th Street, Kansas City, Missouri 64130.



Weighted Wrist Exerciser

Chick Orthopedic Company has developed a new weighted wrist exerciser. The shot-filled, 5-pound exerciser is used to exercise muscles of the phalanges, wrist, elbow, shoulder, and shoulder girdle.

One size fits any adult on either the right or left hand, a Velcro closure assuring snug fit. Made of vinyl, the Chick Wrist Exerciser is easy to clean.

For further information, write: J. Stevens and Son Co. Ltd., 2050 Kipling, Toronto, Ontario.

Specimen Collection Systems Brochure

Sage Products, Inc. has prepared a four-page brochure illustrating and describing their full range of specimen collection containers.

Containers have been designed for all patient specimen requirements — urine, stool, sputum, tissue, and kidney stone. All containers are completely disposable and designed with hospital, lab and patient in mind.

For copies of this brochure write: Sage Products, Inc., 1300 Morse Avenue, Elk Grove, IL 60007.

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Time lost at work due to burns and scratches is effectively reduced by G-63, the pain killer in an aerosol can. One spray of G-63 isolates the affected area with an invisible protective film, helps reduce painful swelling, speeds natural healing through analgesic action, and guards against secondary infection. Neither a cream nor ointment, it does not require bandaging.

G-63 is packaged in 8-ounce spray cans and distributed for export to industry by General Scientific Equipment Company, Limekiln Pike and Williams Ave., Philadelphia, Pa., 19150, U.S.A. Requests for descriptive literature (Bulletin G-63) are invited.

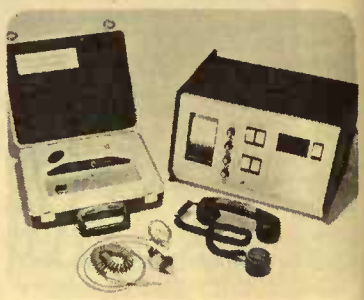
Emergency Trauma Kit

The Cryopac Emergency Trauma Kit offers immediate and effective on-site treatment of injuries, sprains and bruises.

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Compresses are reusable, have indefinite shelf life, and are X-ray transparent. The complete kit is available in a convenient carrying case containing six cans of cryogen, a valve and hose assembly, a boot, glove, and a wrap-around.

Additional information is available from Safety Supply Company, 214 King Street East, Toronto, Ontario M5A IJ8.



Teletrace Telephone EKG System

Medtronic's Teletrace Telephone EKG system uses the public telephone system to provide pacemaker implant centers and follow-up clinics with follow-up data from patients with implanted pacemakers of any manufacturer. From pacemaker patients TeleTrace provides precise digital rate and interval readings from pacemaker activity as well as a quality electrocardiographic trace.

It is also used for monitoring patients for arrhythmia detection, and postinfarct patients for potential rhythm changes, and for interhospital telephone transmission of patients' electrocardiograms for immediate diagnosis of cardiac rhythm disorders.

For information, write: Medtronic of Canada Ltd., 6733 Kitimat Road, Mississauga, Ont., L5N 1W3.

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Books

Critical Care Medicine by Wilbur W. Oaks. New York, Grune and Stratton, Inc., 1974. 473 pages.
Reviewed by Elizabeth Weber, Coordinator, Post-Diploma Program in Adult Intensive Care Nursing, Ryerson Polytechnical Institute, Toronto, Ontario.

Critical Care Medicine is composed of forty articles covering a range of subjects, all related to intensive care areas. These articles are the product of the twenty-eighth Hahnemann Medical Symposium and have been organized into six main headings: Shock and Trauma; Cardiovascular Management; Pulmonary Management; General Intensive Care Unit; Neurologic Emergencies; and Musculoskeletal Emergencies.

Under each main heading, a wide variety of topics are covered. For example, the section on Cardiovascular Management includes topics which run the gamut from the clinical application of monitoring equipment to the mechanism and treatment of pulmonary edema and congestive heart failure. An article on heart block presents a brief look at temporary and permanent pacemakers explaining the indications for pacing, the types of pacemakers available, modes of insertion, and management concerns. A concise review is also given of the pathophysiology and management of cardiogenic shock. Finally, the mechanism of action of the commonly used diuretics is clearly presented in an article on fluid and electrolyte balance in heart failure.

A positive feature of this book is a well-annotated bibliography at the conclusion of each article, that gives the reader a wealth of resources from which to do further readings. Good use is made of charts, X-rays and diagrams to clarify significant points. The major drawback is the brevity of each article, which severely limits the depth attainable. Thus, few articles cover the background pathophysiology of a condition before delving into the specifics of medical management, or reviewing related research findings. Some articles take the form of a brief overview of many aspects of a topic, while others zero in on only one aspect, attempting to ensure depth but tending to limit general appeal.

This book would be of most benefit to experienced intensive care nurses who are seeking further information on topics about which they already have a good understanding. As well, students in postgraduate education and educators may benefit from these readings.

Pain: Clinical and Experimental Perspectives, edited by Matisyohu Weisenberg. St. Louis, The C.V. Mosby Company, 1975. 385 pages.
Reviewed by Dianne Schultz, Teacher, Toronto General Hospital Campus, The George Brown College of Applied Arts and Technology, Toronto.

This is an excellent publication with a multidisciplinary approach to the phenomenon of pain. The emphasis in terms of the experimental view lies in the measurement of pain, its correlates and the variables used to manipulate the pain reaction. The clinical aspect emphasizes measurement, surgery, and clinical techniques independent of drugs for the relief of pain.

The selected readings reflect a comprehensive expression of this problem from various points of view. Section one deals with concepts of pain reactions including the physiology of pain and the psychological aspects. Sections two and three deal with the cultural and social factors and how these influence pain perception, e.g. how children perceive pain, and studies on selected ethnic groups. Section five provides information on the laboratory manipulation of pain perception. Of interest in Section six is a current account of hypnosis and acupuncture in the control of pain while Section seven is dedicated to surgical intervention. Selected diseases and pain associated with them are dealt with in Section eight.

This book will prove invaluable to researchers, clinicians and anyone interested in increasing their knowledge of and ability to control man's problems of pain and suffering.

Guide to Diagnostic Procedures by Ruth French. New York, McGraw-Hill Co., 1975. 357 pages.
Reviewed by Sheila Money, Teacher, Humber College of Applied Arts and Technology, Health Sciences Division, Weston, Ontario.

This book was formerly entitled "The Nurses' Guide to Diagnostic Procedures" but the shorter title is more appropriate, for indeed the book can be used by a variety of health care professionals. The guide is concerned with explanations of fundamental principles, definitions of the common terms associated with diagnosis, the role of the nurse in each of the diagnostic tests, and interpretation of results.

The book is divided into twelve major dvisions. The various procedures are presented under the following headings: urological, hematological, biochemical, specific functions, immunological, immunohematological, microbiological, cerebrospinal, miscellaneous, radiological, and radio-nuclide examinations. The author has done a thorough job of researching the book and it covers all the diagnostic procedures known to this writer. Other texts of diagnostic procedures are often organized according to body systems but in this book the material is well-organized and the excellent index makes it easy to find the desired information.

Since the book will be used in areas where the Celsius scale is used, it would have been helpful if the author had included Centigrade readings when discussing temperatures.

One outstanding improvement in the text is that the normal range for the various tests are given immediately after the heading.

This book would be highly recommended for any unit which does extensive diagnostic testing.

Audiovisual



Health Promotion

King Size
This 7-minute amusing animated film is intended for youngsters but carries a message for adults as well. Anything can happen, and does, including a visit to the kingdom of King Size where "No Smoking" is forbidden. Produced for Health and Welfare Canada and available from regional offices of the National Film Board.

A Fight For Breath - Emphysema
This is a 12-minute, color 16mm film produced by the National Film Board for the Non-Medical Use of Drugs Directorate of the Department of National Health and Welfare. The film features illustrations on the effects of pollutants, e.g., cigarette smoke on the human lung. The theme message is that one out of every seven Canadians suffers from a chronic obstructive lung disease. The film is available to Canadians from any of the regional offices of the National Film Board.

For Those Who Drink
This is a 39 minute black and white film produced by Health Films Limited, Canada. Dr. R. Gordon Bell, a recognized authority on drinking and alcohol problems, narrates this film dealing with drinking and those problems associated with drinking. Some suggestions for a solution to this complex problem are presented in this filmed lecture. To request this film contact the Canadian Film Institute, 303 Richmond Rd., Ottawa, Ontario.

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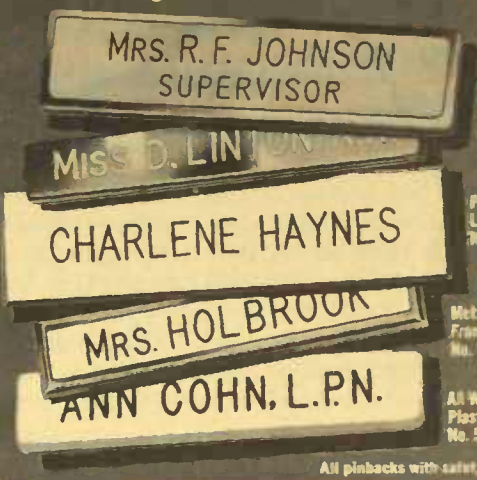
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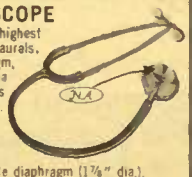
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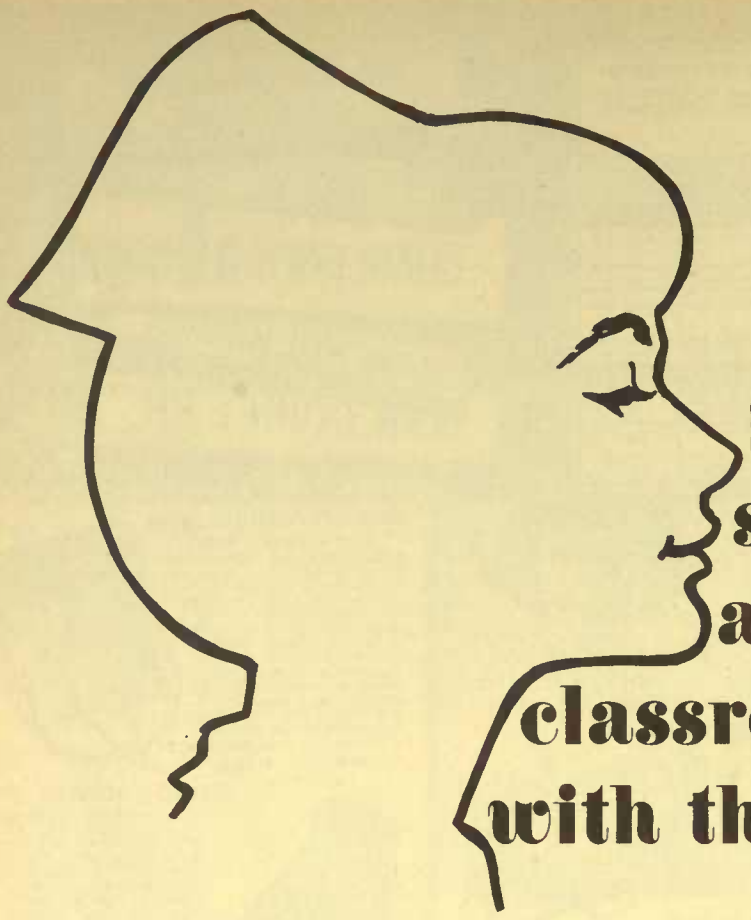
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By Shirley R. Burke, B.S.N., M.S.N.Ed. April, 1976. 2nd edition, 114 pages plus FM I-XIV, 6½" × 9½", 24 illustrations. Price, $5.25.

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By Sandra J. Sundeen, R.N., M.S.; Gail Wiscarz Stuart, R.N., M.S.; Elizabeth DeSalvo Rankin, R.N., M.S.; and Sylvia Parrino Cohen, R.N., M.S. April, 1976. Approx. 240 pages, 7" × 10", 38 illustrations. About $7.90.

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New 9th Edition! INTRODUCTION TO LABORATORY CHEMISTRY. By L. Earle Arnow, Ph.G., B.S., Ph.D., M.B., M.D. January, 1976. 9th edition 102 pages plus FM I-XVI, 5½" × 8½", 43 illustrations. Price, $4.50.

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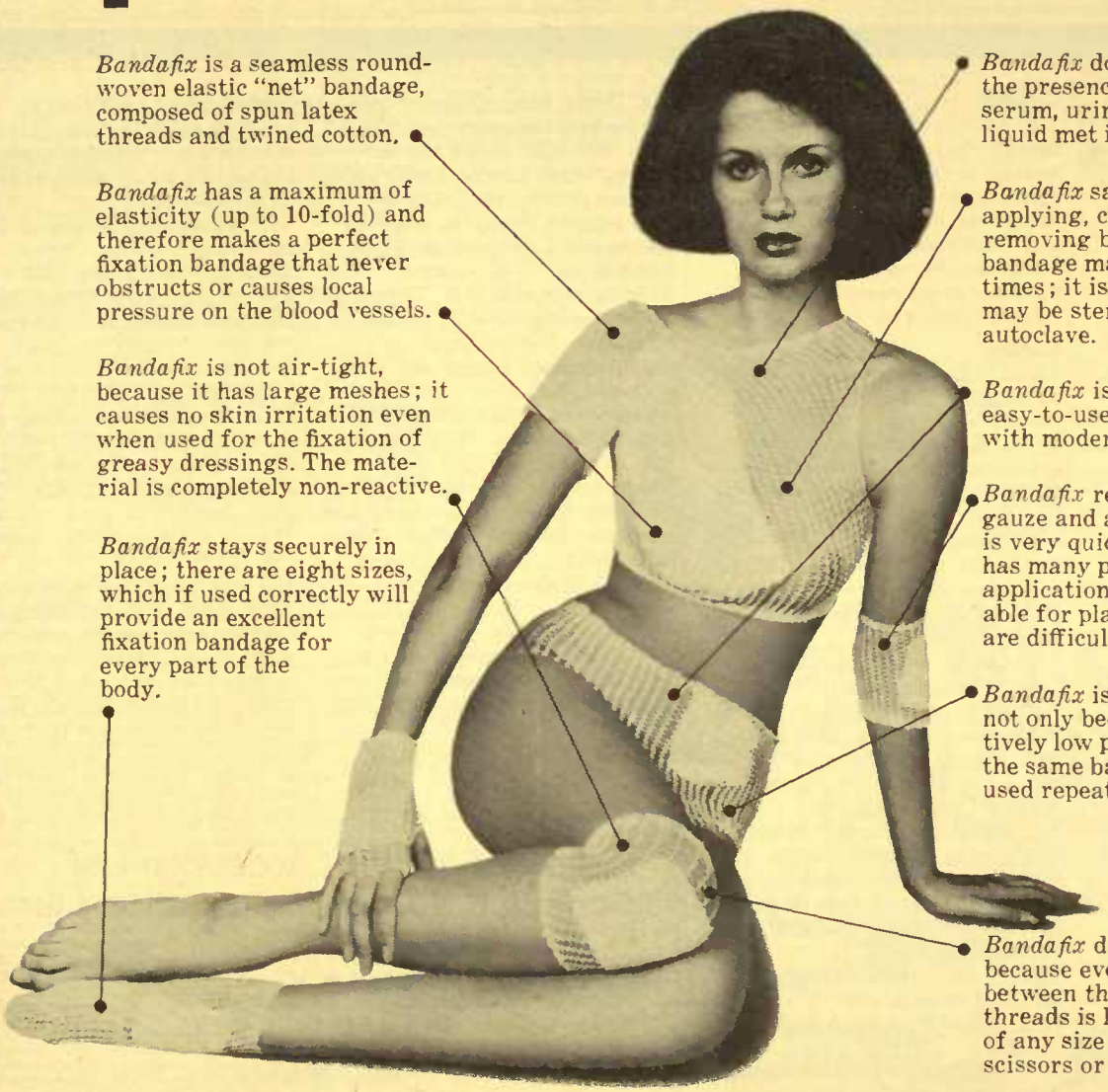
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"As a registered nurse with more years experience behind me than I care to think about, I know how important it is to keep growing in your job—to avoid that awful feeling of being stuck in the same rut. Certainly what you're doing is tremendously worth-while, and heaven knows there is a desparate shortage of nurses. But your job must be worthwhile *to you*, or else you'll eventually want to drop out".

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"As far as you're concerned, however, the key phrase is "Temporary Assignments". Because, as you can see by the chart above, you can choose just about any working condition, or shift, or professional discipline you want". "It comes down to this: if you want more from nursing than you're getting now, talk to Medox".

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Rehabilitation Nursing

The Toronto Western Hospital Campus of the Nursing Division offers a two-part program in Rehabilitation Nursing for Registered Nurses, who wish to develop their understanding and skills in this aspect of nursing.

Admission Requirements: Applicants must hold valid registration as a nurse in a province or territory of Canada and have at least one year's nursing experience. Applicants for Part II of the program, must have successfully completed Part I or an acceptable equivalent.

Part I — April 12 - May 7, May 10 to June 4 and June 14 to July 9, 1976.

Part II — March 15 - April 2 and July 12 - July 30, 1976.

For further information or application forms, contact the:
Admissions Officer (Nursing)
The George Brown College
Box 1015 Station B
Toronto, Ontario
M5T 2T9 or Telephone: (416)967-1212

Memorial University of Newfoundland
School of Nursing

Memorial University of Newfoundland School of Nursing, St. John's, Newfoundland, Canada, has faculty positions available September 1, 1976 or January 1, 1977 for teachers with knowledge of Curriculum Development and competency in Nursing of Children, Maternal-Child Nursing, Psychiatric Nursing, and Community Nursing.

There are also opportunities for joint appointments with the appropriate nursing departments in the City. *Masters degree preferred.*

Direct applications to:

Margaret D. McLean
Director, School of Nursing
Memorial University of Nfld.
St. John's, Newfoundland.

The Montreal Children's Hospital

Registered Nurses
Nursing Assistants

Our patient population consists of the baby of less than an hour old to the adolescent who has just turned seventeen. We see them in Intensive Care, in one of the Medical or Surgical General Wards, or in some of the Pediatric Specialty areas.

They abound in our clinics and their numbers increase daily in our Emergency.

If you do not like working with children and with their families, you would not like it here.

If you do like children and their families, we would like you on our staff.

Interested qualified applicants should apply to the:

Director of Nursing
Montreal Children's Hospital
2300 Tupper Street
Montreal 108, Quebec

SOFRA-TULLE® **Roussel**
Sulfate de framycétine B.P. **Antibiotique**

Indications: Traitement des brûlures, des lésions d'écrasement, des lacérations, infectées ou susceptibles de l'être, Ulcères variqueux, escarres de décubitus et plaies ulcérées.

Contre-indications: Allergie connue à la lanoline ou à la framycétine. Organismes résistants à la framycétine.

Mise en garde: Dans la plupart des cas, l'absorption de l'antibiotique est si faible qu'on peut la considérer comme négligeable. Toutefois, si Sofra-Tulle recouvre une grande surface (p. ex. une brûlure s'étendant sur 30% ou plus du corps), il existe un risque d'ototoxicité ou de néphrototoxicité. L'emploi prolongé des antibiotiques peut résulter en une prolifération des organismes non-sensibles, incluant les champignons. Dans de tels cas, des mesures appropriées doivent être prises.

Posologie: Appliquer directement une seule couche sur la plaie et la couvrir d'un pansement. Si la plaie suinte abondamment, renouveler le pansement au moins 1 fois par jour. Dans les cas d'ulcères, découper la compresse selon le contour de l'ulcère pour réduire le risque de sensibilisation et pour ne pas déborder sur l'épiderme environnant.

Présentation: Pansement de gaze légère, paraffinée, contenant: 1% de sulfate de framycétine B.P. Sofra-Tulle contient également 9.95% de lanoline anhydre. Disponible en unités simples stériles de 10 cm sur 10 cm, boîtes de 10 et 50 et en unités simples stériles de 10 cm sur 30 cm, boîtes de 10.

Conserver à la température ambiante contrôlée.

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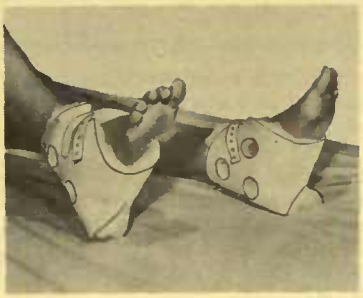
Contact:
Anne D. Thorne
Saint John School of Nursing
Beaverbrook House
Coburg Street
Saint John, New Brunswick
Phone No. (506) 658-2203

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Major renovation program scheduled for 1976-77. Previous experience desirable. Duties to commence June 1, 1976.

Please forward complete resume of experience and qualifications to:

The Administrator
Macleod Municipal Hospital
Fort Macleod, Alberta
T0L 0Z0

Assistant Director of Nursing

Assistant Director of Nursing required for an accredited 130-bed General Hospital with a major expansion project underway.

The city of Grande Prairie is located 285 miles northwest of Edmonton and is well serviced by bus and air.

Preference will be given to applicant with practical experience at the senior administration level combined with baccalaureate degree and/or other formal education in the field of administration.

Salary commensurate with education and experience.

Position available by May 1st 1976.

Please apply to:
Director of Nursing
Grande Prairie General Hospital
Grand Prairie, Alberta
T8V 2E8

North Newfoundland & Labrador requires

Registered Nurses
Public Health Nurses

International Grenfell Association provides medical services for Northern Newfoundland and Labrador. We staff four hospitals, eleven nursing stations, eleven Public Health units. Our main 180-bed accredited hospital is situated at St. Anthony, Newfoundland. Active treatment is carried on in Surgery, Medicine, Paediatrics, Obstetrics, Psychiatry. Also, Intensive Care Unit. Orientation and In-Service programs. 40-hour week, rotating shifts. Living accommodations supplied at low cost. **Public health** has challenge of large remote areas. Excellent personnel benefits include liberal vacation and sick leave. Union approved salaries start at $810.00.

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Guelph, Ontario
N1E 4J4
Telephone: (519) 822-5350 Ex.: 203

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required in a 2 year English language diploma Nursing program

Qualifications
Master's degree in Nursing Education, preferred, with experience in Nursing Education.
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Eligible for registration in New Brunswick.

Apply to:
Harriett Hayes
Director
The Miss A.J. MacMaster School of Nursing
Postal Station A, Box 2636
Moncton, N.B.
E1C 8H7

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For a 138-bed Active Treatment Regional Hospital in Medicine, Surgery, Paediatrics, Obstetrics, and qualified R.N.'s for a 5-bed I.C.U.-C.C.U.
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The Hospital is located in the beautiful Annapolis Valley which is a one-hour drive to the Provincial Capital of Halifax.

Apply to:
Director of Nursing
Blanchard-Fraser Memorial Hospital
186 Park Street
Kentville, Nova Scotia
B4N 1M7

Operating Room Supervisor

- required for 650-bed fully-accredited hospital
- management experience and advanced preparation in Operating Room technique and administration required

Please apply giving full resume to:

Director of Personnel
Lions Gate Hospital
230 East 13th Street
North Vancouver, British Columbia
V7L 2L7

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Co-ordinator required for a 340-bed acute care hospital in Central British Columbia to be responsible for the related services of the O.R., P.A.R., Daycare Surgery and Emergency Departments. The position will include both clinical and administrative responsibilities.

Salary per RNABC Contract.

For further information contact:

Director of Nursing
Prince George Regional Hospital
Prince George, British Columbia
V2M 1S9

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Clinical areas include: medicine, surgery, obstetrics, paediatrics, psychiatry, activation & rehabilitation, operating room, emergency and intensive and coronary care unit.
Must be eligible for B.C. Registration.
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Shift differential

Apply to:
Director of Nursing
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Prince George, B.C.

Registered Nurses and Nurses Assistants

required for 110-bed hospital for chest diseases situated in the Laurentians, 55 miles north of Montreal.
Salaries are now being updated.
Excellent fringe benefits.
Quebec language requirements do not apply for Canadian applicants if registered in Quebec before July 1976.

Apply:
Director of Nursing
Mount Sinai Hospital
P.O. Box 1000
Ste-Agathe des Monts, Quebec
J8C 3A4

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We offer an active staff development program in a 310-bed General Hospital involved in Acute, Extended and Mental Health Care.
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Apply, sending complete resume, to:
Director of Personnel
Stratford General Hospital
Stratford, Ontario
N5A 2Y6
(Area Code 519, 271-2120, Extn. 217)

Foothills Hospital, Calgary, Alberta

Advanced Neurological-Neurosurgical Nursing for Graduate Nurses

A five month clinical and academic program offered by The Department of Nursing Service and The Division of Neurosurgery (Department of Surgery)
Beginning: March, September

Limited to 8 participants
Applications now being accepted

For further information, please write to:
Co-ordinator of In-service Education
Foothills Hospital
1403 29 St. N.W. Calgary, Alberta
T2N 2T9

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and Ambulance Attendant Program based in Orillia

New, progressive, integrated curriculums. If you are a creative and innovative teacher, if you believe in self-directed learning, we would like you on our staff.

Starting date August 17, 1976 with 2 weeks orientation.

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Miss C.M. Brown
Nursing Administrator
Georgian College of Applied Arts & Technology
43 Colborne Street West
Orillia, Ontario. L3V 2Y5

Téléphone: (705) 325-2705

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A Teaching Hospital of McGill University

requires .

Registered Nurses and Registered Nursing Assistants

- 255-bed General Hospital in the West of Montreal
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Interested qualified applicants should apply in writing to:

Queen Elizabeth Hospital of Montreal Centre
Director of Personnel
2100 Marlowe Ave., Montreal, Quebec
H4A 3L6

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Nurse faculty members required for the 1976-77 academic year for a School of Nursing, within a Faculty of Health Sciences. The School is an integral part of a newly developed Health Sciences Centre where collaborative relationships are fostered among the various health professions and clinical appointments can be arranged.

Requirements: master's or doctoral degree, with clinical specialist preparation or experience and/or preparation in teaching preferred in adult health, medical-surgical or pediatrics.

Application, with a copy of curriculum vitae and two references to:

Dr. D. Kergin
Associate Dean (Nursing)
Faculty of Health Sciences
McMaster University Health Sciences Centre
1200 Main Street West
Hamilton, Ontario
L8S 4J9



SUMMER IN THE ARCTIC?

Medical Services, Northwest Territories Region, is offering a number of term positions for qualified and experienced nurses to serve Canada's northland during the period of May through September.

Why not see the Arctic and experience the challenge of frontier health care?

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Personnel Administrator, Medical Services, Northwest Territories Region, Health and Welfare Canada, 14th. Floor, Baker Centre, 10025 - 106 Street, Edmonton, Alberta. T5J 1H2

or call collect Area Code 403 - 425-5698

NOTE: Permanent positions with Northern Health Services are also available.

Health and Welfare Canada Santé et Bien-être social Canada

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Corner Brook, Newfoundland.

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For a 350 bed fully accredited, acute treatment, Regional General Hospital serving a population of approximately 100,000, scenic City with modern shopping, housing and education facilities.

Salary Scale: $ 9,724.00 — 11,986.00 per annum
10,324.00 — 12,586.00 per annum *1st April, 1976*
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Service Credits recognized.

Shift Differential — $1.50 per shift.
Charge Nurse — 3.00 per shift.
Uniform Allowance — 90.00 per year.

Educational Differential — Extra three steps on salary scale for B.N. Degree, four steps for Masters Degree.

Annual Vacation — Twenty days.

Statutory Holidays — Eight plus Birthday.

Residence accommodation available $35.00 per month.

Transportation available.

Applicants please apply to:
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4 Herald Avenue
Corner Brook
Newfoundland
A2H 6J7



General Staff Nurses

required for

Regina General Hospital

openings in all departments

Recognition Given For Experience
Progressive Personnel Policies

Apply:

Personnel Department
Regina General Hospital
Regina, Saskatchewan
S4P 0W5

HUMBER COLLEGE

HEALTH SCIENCES DIVISION

requires

Director, Quo Vadis Campus

Duties

Successful Candidate will be responsible for the academic administration and development of a unique diploma nursing program for adult nurse learners within a peer-oriented setting, the development and administration of formal and informal continuing education programs for registered and non-registered nurses and registered nursing assistants and the effective operation of the Quo Vadis Campus.

Qualifications

The successful applicant will be a nurse registered or eligible for registration in Ontario and will have a graduate degree and broad experience in adult education, nursing and/or education administration. Preference will be given to candidates with recent experience in developing programs for and working with adult learners.

Director, Osler Campus

Duties

Successful Candidate will be responsible for the academic administration and implementation of the nursing diploma program on the Osler Campus, providing leadership in educational design and teaching/learning approaches, the effective operation of the Osler Campus and the management of the residence.

Qualifications

The successful applicant will be a nurse registered or eligible for registration in Ontario and will have a graduate degree in nursing, education or administration. Preference will be given to candidates with recognized experience and expertise in curriculum development and/or educational leadership.

Apply in writing with resume to:

Personnel Relations Centre
Humber College of Applied Arts & Technology
P.O. Box 1900, Rexdale, Ontario M9W 5L7

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ntroduction
position has been created in mental health/public health
ursing in the town of Frobisher Bay, N.W.T. Frobisher
ay has a population of 3,000 and is located 1,300 miles
orth of Montreal. Two mental health/public health nurses
re currently employed-one in Yellowknife and one in
nuvik.

Duties
The mental health/public health nurse is responsible for
dentifying mental health problems in the community;
rranging for mental health care treatment to patients
nd for implementing generalized public health nursing
rograms.

Qualifications
Eligibility for or registration in a province or territory
f Canada. Certificate or Baccalaureate in Public Health
Nursing or in a specialty relevant to the duties of the
osition. Nursing experience and demonstrated compe-
ence in psychiatric nursing. Knowledge of English is
ssential.

How to Apply
Forward completed "Application for Employment" (Form PSC 367-4110) available at Post Offices, Canada Manpower Centres or offices of the Public Service Commission of Canada, to:

Mr. Rusty Gabert
Personnel Administrator
Medical Services, Northwest Territories Region
4th Floor, Baker Centre
0025 - 106 Street - Edmonton, Alberta T5J 1H2

Please quote the applicable reference number at all times.



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NAME: _____
ADDRESS: _____
_____
PHONE: _____
SPECIALITY INTEREST: _____
DATE AVAILABLE: _____

Cancer Control Agency of British Columbia
Associate Director for Nursing

This new agency has been established to develop a comprehensive cancer program for Canada, West of the Rockies. Programs of early detection, education including nursing and paramedical, advanced therapeutics and research are being initiated. Expansion of the role of the nurse in each of these areas is needed, and innovative programs will be developed. This is an exciting new position and carries responsibilities for the co-ordinating of all nursing services within the Cancer Control Agency (including a 56 bed hospital unit, currently being expanded into 85 beds, an outpatient clinic with 30,000 visits yearly) as well as an active planning program for extension of cancer nursing services and education throughout the province of B.C.

Applicants should have university training suitable for an appointment at the University of B.C., and proven competence in supervision and nursing education and administration.

Send letter of application, together with a detailed resume and expected salary range to:

Thomas C. Hall, M.D.,
Director
Cancer Control Agency of British Columbia
2656 Heather Street,
Vancouver, B.C. V5Z 3J3

Supervisor-Surgical Suite
Rockyview Hospital

Applications are presently being accepted for a senior nursing position which evolves around the administrative and clinical responsibility of complete Operating Room and Recovery Room staff and procedures.

Candidates must be eligible for registration in the Alberta Association of Registered Nurses. A degree in nursing or Nursing Unit Administration course preferred. Post graduate preparation in Operating Room nursing desirable.

Applicants must possess recent senior experience in Operating Room and Recovery Room care. Experience in all specialities. Successful applicant must be able to commence employment by at least March 1, 1976.

Interested applicants are asked to submit a written resume to:

Hospital District No. 93
Personnel Department
940 Eighth Avenue S.W.
Calgary, Alberta
T2P 1H8

Registered Nurses

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- Intensive care
- Coronary observation unit
- Cardiovascular surgery
- Burns and plastics
- Neonatal intensive care
- Renal dialysis
- Neuro-surgery

Planned Orientation and In-Service Education programs. Post Graduate clinical courses in Cardiovascular — Intensive Care Nursing and Operating Room Technique and Management.

Apply to:
Recruitment Officer — Nursing
University of Alberta Hospital
112 Street and 84 Avenue
Edmonton, Alberta T6G 2B7

University of Alberta Hospital

Edmonton, Alberta

Brandon General Hospital
School of Nursing

Nurse Teachers
for Two Year Diploma Program
Positions Available July, 1976
in Nursing Content Areas of
"Fundamentals" — "Maternal — Child"
"Medical-Surgical" — "Psychiatric Nursing"

Qualifications
Baccalaureate Degree in Nursing is required.
Preference given to applicants with experience in Nursing and Teaching.

Apply in writing stating qualifications, experience, references to:

Personnel Director
Brandon General Hospital
150 McTavish Avenue East
Brandon, Manitoba
R7A 2B3

657 bed, accredited, modern, well equipped General Hospital, rapidly expanding...



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Saint John, N.B., CANADA

REQUIRES:

General Staff Nurses & Registered Nursing Assistants

In all general areas: Medical, Surgical, Pediatrics, Obstetrics, Chronic and Convalescent, several Intensive Care areas and Psychiatry.

- *Active, progressive in-service education program. Special Attention to Orientation.*

Allowance for Experience and Post Basic Preparation

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Saint John General Hospital
P.O. BOX 2000 Saint John, New Brunswick E2L 4L2

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Director, Nursing Service
Jewish General Hospital
3755 cote ste. Catherine Road
Montréal, Québec
H3T 1E2

The Registered Nurses' Association of Nova Scotia

invites applications for the position of

Executive Secretary

The applicant should have a broad nursing background, administrative experience and university preparation, preferably at the Master's level. A background in professional association activities would be an asset.

Applications for this position will be accepted until September 1, 1976.

For complete information, including job description and salary range, write to:

President
Registered Nurses' Association
of Nova Scotia
6035 Coburg Road
Halifax, N.S. B3H 1Y8

Clinical Co-Ordinators
required for
Medicine Hat & District Hospital

This is the active treatment, rehabilitation and extendicare portion of a 567 bed total health care complex in Medicine Hat, Alberta — the energy city of the west.

A complete reorganization and major expansion of all facilities of the 247 bed active treatment hospital is in progress with concomitant nursing care programs. Medicine Hat & District Hospital is involved in a number of pilot projects in Alberta.

Positions:
(1) Clinical Co-ordinator, General Medical — Surgical.
(2) Clinical Co-ordinator, Special Services — Acute Care.

Our Clinical Co-ordinators are both Clinical Nurse Specialists and Administrators of his or her clinical area. Co-ordinators report directly to the Assistant Executive Director of Patient Services.

A cross appointment in the college nursing program may be recommended.

Qualifications:
(1) A Master of Science Degree in Nursing, preferred.
(2) Advanced clinical knowledge and expertise.

Salary:
Minimum — $17,000.00

Position Open:
April 1st, 1976.

Submit Resume To:
Mrs. Gwynneth Paterson
Assistant Executive Director — Patient Services
Medicine Hat & District Hospital
Fifth Street, South West
Medicine Hat, Alberta

Vancouver General Hospital

Invites applications for

Regular and Relief
General Duty

Nursing positions in all clinical areas of an active teaching hospital, closely affiliated with the University of B.C. and the development of the B.C. Medical Centre.

For further information, please write to:

Personnel Services
Vancouver General Hospital
855 West 12th Ave.
Vancouver, B.C.
V5Z 1M9

Sherbrooke Hospital
Sherbrooke, Quebec
invites applications from

Registered Nurses
General Duty

138-bed active General Hospital; fully accredited with Coronary, Medical and Surgical Intensive Care. Situated in the picturesque eastern Townships, approximately 80 miles from Montreal via autoroute. Friendly community, close to U.S. border. Good recreational facilities. Excellent personnel policies, salary comparable with Montreal hospitals.

Apply to:

Director of Nursing
Sherbrooke Hospital
Sherbrooke, Quebec

Nursing Coordinator

Responsible for coordination of all nursing activities to the delivery of quality care in all nursing stations and Harrington Hospital of the Lower North Shore of Quebec. Must be bilingual.

Registered Nurses

to join our team on the Lower North Shore to Quebec Dispensaries. Salary according to collective agreement and M.A.S.

Advantageous benefits.

Isolation premium.

Residence accommodation.

Send complete resume to:

Director of Personnel
Hôpital Notre-Dame
Lourdes du Blanc Sablon
Duplessis, P.Q.
Tel.: (418) 461-2144

Faculty Positions

1 Professor or Associate Professor of Nursing to coordinate the Master's Program in association with the Director of the School. It is expected that the candidate would have completed a doctorate, and have had clinical, nursing education and research experience. The appointment includes teaching in the graduate and undergraduate programs, and provides opportunity for research.

2 Because a number of our faculty will be leaving to pursue further education at the end of this academic year, there will be positions available for qualified faculty. We are especially interested in candidates with preparation in mental health and psychiatric nursing, and in community health nursing.

Interesting developments for the future make Dalhousie School of Nursing a challenging place in which to contribute to nursing education and to further one's own professional goals.

- new and modern quarters for the School are planned
- our masters program is now in its first year
- some research projects are getting underway and Dr. Margaret Scott Wright from Edinburgh, well known in Canada and internationally, will be our new Director.

Applications, with curriculum vitae, should be sent to Muriel E. Small, Director, School of Nursing, Dalhousie University, Halifax, Nova Scotia.



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if you care, send this coupon today.

Medical Services Branch
Department of National
Health and Welfare
Ottawa, Ontario K1A OK9

Please send me more information on nursing opportunities in Canada's Northern Health Service.

Name: _____

Address: _____

City: _____ Prov: _____

Health and Welfare Canada | Santé et Bien-être social Canada

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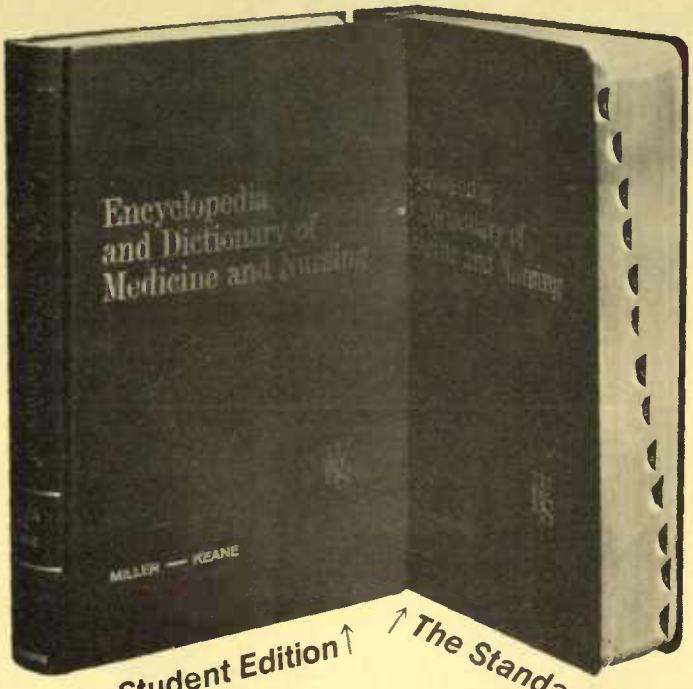
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CNA member associations will name 249 voting delegates to officially represent their membership at the national association's Annual Meeting in Halifax this June. For these nurses, it will be business before pleasure when the time comes to voice the wishes of the people they represent. The cover photo of voting delegates at a previous CNA meeting is by David Portigal of Winnipeg.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses' Association.

ISSN 0008-4581

Indexed in International Nursing Index, Cumulative Index to Nursing Literature, Abstracts of Hospital Management Studies, Hospital Literature Index, Hospital Abstracts, Index Medicus. *The Canadian Nurse* is available in microform from Xerox University Microfilms, Ann Arbor, Michigan, 48106.

The Canadian Nurse welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-space. Send original and carbon. All articles must be submitted for the exclusive use of *The Canadian Nurse*. A biographical statement and return address should accompany all manuscripts.

Subscription Rates: Canada: one year, $8.00; two years, $15.00. Foreign: one year, $9.00; two years, $17.00. Single copies: $1.00 each. Make cheques or money orders payable to the Canadian Nurses' Association.

Change of Address: Notice should be given in advance. Include previous address as well as new, along with registration number, in a provincial nurses' association where applicable. Not responsible for journals lost in mail due to errors in address.

Postage paid in cash at third class rate Montreal, P.Q. Permit No. 10,001.
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Perspective

Three years ago, when doing some reading in the area of the probable fate of professional associations as an organized entity, I happened across a comment by a North American sociologist that "the danger for many associations in existence today, lies in the very distinct possibility that they will not adapt themselves sufficiently to survive the coming decade."

And right here I must admit that, in 1973, the threat that a good many of the professional associations that existed at that time, would simply not be around in the eighties did not seem either very immediate or very ominous. After all, change has become an accepted characteristic of our contemporary conditiion. A degree of introspection is a healthy sign and adaptability is the mark of the well-adjusted institution or individual. Professional associations had been around for a long time and would probably continue to meet the needs of their members in one way or another for a long time to come.

But now, in the Spring of 1976, our association is faced with a crisis that threatens its very existence. Can we change fast enough to meet the challenge not just of new social attitudes and scientific advances, but also of an economic turnaround that directly or indirectly affects everyone who gives or receives health care services in this country?

And this is precisely where the problem lies. Funding for the 1976-78 biennium has become a critical issue for this association. And, right now (not 3 years ago or even 4 years from now) is the time the nursing profession stands most in need of the kind of strength, leadership and direction that can be obtained only by collective action at the national level.

Recently, it has become apparent that the lip-service that has been given publicly to health promotion, illness prevention, and the need to find viable alternatives to acute care, is going to have to be replaced by concrete action. The implications for the nursing profession of this revolution in our health care system, are profound. Very soon, we could be looking at broader nursing roles, new responsibilities, more independent professional recognition, more group practice, more inter-professional cooperation, more opportunities for promotion and, potentially, a very real increase in the "political clout" that the profession can command. But (and this is a very big *but*) the only way that nursing can achieve, on a national scale, the kind of scientific expertise, information retrieval and dissemination systems, and climate of public confidence that will allow this to happen is by pooling its resources and working collectively for the advancement of the profession as a whole.

Today, there is more truth than ever in Robert Merton's comment that "in the professions, each practitioner is his brother's keeper." The future of the future is the present. For CNA, that present is as close as June 22, 1976. On that day, you or your representatives will decide the future of organized professional nursing in this country. Are you ready to assume that responsibility?

— M.A.H.

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Carol Thiessen
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Mary Lou Downes
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Herein



The wistful face above belongs to little Theresa Bakx who lost her arm in an accident. A first-person account by one of the nurses involved in the subsequent replantation is on page 19 of this issue.

Next month, what happens when a patient in your hospital dies? Who is responsible for helping the family over the inevitable hurdles they face in the first shock of their bereavement? What happens when no one accepts this responsibility is the subject of one of next month's articles.

Also next month, an examination of the nursing care involved in transportation of the sick neonate — the steps you can take during and before this move to reduce the risks to the patient.

Just before press time, members of the program committee were able to provide some last minute information on the June CNA meeting in Halifax. (see pages 35-37 of this issue). Participants in Monday's debate, in addition to those named, will include: Brenda Allt, assistant executive director, Patient Services, Halifax Infirmary, and Denise Lalancette, chargé d'enseignement, Centre Hospitalier Universitaire, Sherbrooke (in favor); Margaret McLean, director, school of nursing, Memorial University, St. John's, Nfld. and Suzanne Brazeau, doctoral candidate, University of Chicago, (against).

Ruth May, assistant professor, Outpost Nursing, school of nursing, Dalhousie University, will also be a member of the group of nurses that Patrick Watson will interview. Participants in the panel discussion on the quality of life in the work world o the nurse will also include André Payeur, lawyer, who will discuss "Uncertainties regarding the nurses' legal protection."

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Input

A warm reception

I have just finished my January 1976 issue of *The Canadian Nurse*. I like the new format very much and particularly I enjoyed the article "Crying."
Joan Pattie, R.N., Kentville, N.S.

If first impressions are accurate, it's super. Certainly has impact via the graphics, new type face, column widths, etc. It really looks *alive!* Congratulations!
Nancy Rideout, Liaison Officer, NBARN.

What is there to say about a change in format as radical as the one which faces readers of *The Canadian Nurse*? I like it! There is something deep beneath this new format which I feel is brewing and about to mature into a much more informative journal.
Donna Grey, N., B.N., Montreal, Quebec.

May I take this opportunity to commend you and the journal staff for the realization of long-desired goals for a professional magazine.

If Volume 72, Number 1 is any indication we note a new expression of our professional status.
Donna M. Wells, Dean, Nursing Programmes, Seneca College of Applied Arts and Technology, Willowdale, Ont.

I am writing to tell you how much I have enjoyed the first two issues in 1976 of *The Canadian Nurse* . The cover is striking, and yet pleasing . The articles are truly more personal. I feel like some of the authors are sitting across the table talking to me. Also you look like you are having fun from the manner of writing, the titles of the articles, and the design of the journal...I can proudly recommend this journal to R.N. students.
Jeanette R. Linton, R.N., B.Sc.N., teacher, Confederation College, Thunder Bay, Ontario.

and criticism ...

For people like myself with rather mild vision problems the type is too small for comfort. I find it a real strain to read. Also — and I can't tell if it is the type size, or line length — I find it almost impossible to scan articles. This means reading every word, rather slowly, or just skipping it altogether. Maybe we should have a rapid reading specialist study it?

Best wishes in trying to improve the journal.
Helen Elfert, University of British Columbia, School of Nursing, Vancouver.

The editor replies: Our first "new look issues" brought many compliments. We're glad you think we're moving in the right direction in the areas of both design and content.

We're even more delighted that so many of you were motivated to write, phone or drop in to say "thank you." It's this kind of input from "you out there" that is really at the root of change. Please, keep the lines of communication open.

"Frankly Speaking"

I read your commentary on UIC in *The Canadian Nurse* December '75 with great interest. I was called for a UIC interview just the next day.

This interview went along as your article had forewarned me. The interviewer tried to channel me out of nursing, and convince me to seek full-time employment— of which there is little in this area since new graduates are working casual part-time. I have since received a disentitlement which I am appealing.

With the present budget cutbacks and the closing of hospitals, I see the plight of nurses seeking employment looking very dark indeed. Does the government intend to deny claims to all those part-time nurses who will soon be unemployed? Where could they all find full-time jobs anyway?

If all of us are going to be looking for full-time employment in order to collect a few UIC dollars the Manpower list will remain crowded with R.N.'s names for a long while.

Where do we go from here?
Glenna Lane, Kingsville, Ontario.

CNA member-at-large for social and economic welfare, Glenna Rowsell, indicates that this is one of many similar letters received in response to her December column, "Working with you between jobs???"

For readers who experience problems, she suggests: "Guidelines for eligibility for UIC benefits are laid down by federal statute. Any problems that arise are caused by local variations in interpretation of the law and, therefore, the best approach is at the local-provincial level. If you have a problem, look first to your provincial nurses' association for assistance.
Editor's note: see also page 9 this issue (CNA Directors request UIC officials to work with provincial associations at local levels).

Nursing abroad

The article "Cross Canada Registration" (The Canadian Nurse, January 1976) made me aware of the services offered by CNA's nursing coordinator.

I've been planning a trip abroad, and have questions concerning the licencing requirements and procedures for Zaire. Could you provide this information or an address where I could procure the necessary information for myself?

Another question: Is there any sort of International Nurses Licence? I could be traveling in Africa for several months, and have wondered about the possibility of obtaining a licence which would be valid in several countries.

Thank you again for the informative article!
Joanne Buttery, Montreal, P.Q.

The article to which this reader refers has resulted in a flood of enquiries to the CNA Nursing Coordinator. Many writers ask about "international licensure" and other aspects of employment abroad.

The Nursing Coordinator reminds them that several factors should be considered if you are thinking of travel and work abroad.

1. The ICN Nursing Abroad Program applies only to Canadian nurses who are members of CNA. This means that to be eligible you must be a member of a professional association such as RNAO, ONQ, etc.
2. In order to nurse patients effectively, you must be able to communicate with them. Therefore, you must be able to speak the language of the country where you plan to work.
3 You should expect to work for at least six months, preferably a year, in each place you plan to visit. Arranging for positions and orientation is expensive for the host country.
4. International licensure definitely does not exist. In fact, it would seem to be a long way off when you consider that there are still 10 registering bodies in Canada.

What is it?

Some time in early January, the December *Canadian Nurse* arrived in my mailbox. This is a pleasure to which I look forward monthly: all that nursey news and medical knowledge, keeping me up-to-date with my profession. But — there was something radically amiss with the cover — it was wildly colored and shaped; or rather it had no shape at all. Someone had made a mistake and put on another magazine's cover picture.

Perhaps it was *The Canadian Traffic Engineer:* a schematic of a traffic interchange for downtown Toronto? (or Montreal, if you like)

Was it *The Scientific American:* a spinning DNA molecule?

Or *Rolling Stone:* what you will see with the effects of some marvellous new psychedelic substance that may be smoked, sniffed, shot or swallowed?

Chatelaine: what the well-dressed woman will wear this spring.

Pharmaceutical Journal: a capsule, at last, that will cure the common cold.

Arts Canada: the latest abstract triumph by a current Canada Council painter.

Maybe it is a design for the next Canadian stamp in honor of Florence Nightingale.

Finally I decided that it must be a whirling Christmas tree photographed as a time exposure with the little white angel left off the top of the picture.

It's pretty, and I like it, but really, what is it?
Sara M. Cooper, RN, BSN, Sardis, B.C.

The editor replies: Our correspondent wins the December guessing contest. We hope she, and all our other readers, appreciate the word of explanation that now appears in each issue telling them about the cover photo and photographer.

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News

Proposed fee raise to be submitted to general assembly

As anticipated at the last meeting, members of the CNA Board of Directors took measures at a February meeting to cope with the Association's financial problems. In addition, concerns such as rape, cutbacks in hospital beds and anti-inflationary measures were discussed and acted upon.

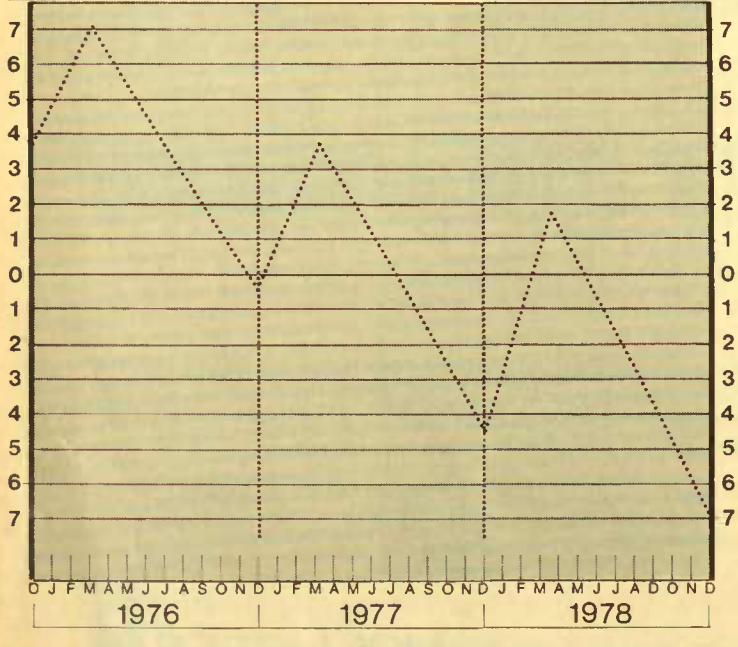
Minimal fee raise recommended

CNA Directors faced a difficult situation at the February 1976 Board meeting. Inherent in the $423,779 expected deficit for 1976 is the stark financial reality that CNA is fast depleting its cash reserves in order to meet rising costs.

By the end of 1976, these reserves will have been exhausted. Steadily rising costs without offsetting revenue increases, plus the need to repay the mortgage that falls due this year, have created this situation. Faced with the prospect of great financial hardship if the present level of revenue is maintained, Directors had no choice but to consider a raise in fees. The present formula for calculation of association member fees is based on a $10.00 unit assessed as follows:

1/2 unit — first 250 members
3/4 unit — 251 to 1000 members
1 unit — 1001 to 15,000 members
3/4 unit — 15,001 to 25,000 members
1/2 unit — 25,000 members and up

Working capital & debt forecast 1976-1978
based on a $12. unit in 1977 and $15. unit in 1978



Peaks represent maximum working capital during the year; valleys depict increasing cumulative debt at the end of each year. This projection is based on the assumptions that 1. membership will increase 4 percent per annum; 2. the inflation rate will be 10 percent; 3. programs will remain at the 1976 budget level and 4. the Testing Service will be self-supporting.

However the formula also stipulates that "no one association will pay more than one third of CNA fee revenue for the preceding year."

Several fee proposals were received. Serious discussion revealed the concern of Directors over the ability of member associations to pay additional money. The unit finally agreed upon was $12.00 for 1977 and $15.00 for 1978. This would mean that CNA would be receiving approximately $10.00 in 1977 and $12.50 in 1978 per ordinary member via member associations. The net effect of this would be to incur additional debt of approximately $400,000 in 1977 plus $250,000 in 1978. A unit fee of about $17.50 would be required to break even in these two years.

A clear-cut statement on budgetary curtailments

In response to the budgetary curtailments being imposed on health care services in Canada, the CNA Board of Directors issued the following statement:

"The cost of health care services in Canada has become a national concern. Nurses share that concern and agree that steps have to be taken to contain expenditures. The escalation of these costs, however, comes as no surprise, for the health care system has relied on and was indeed conceived around, the delivery of acute care. Acute care is the most costly type of care and is not necessarily the best investment.

The Canadian Nurses' Association has repeatedly requested that governments put forth some plan to refocus the Canadian system of care in order to expand services in the areas of health education, health promotion and primary care. Groups of nurses across the country at the present time are arguing that we need to provide some realistic alternative to our reliance on acute care.

Nurses protest when curtailments are applied indiscriminately. Cuts in the number of acute care hospital beds in provinces across the country could be understood and supported. What is not understood nor accepted is that:

1. in some cases, these curtailments are being applied across the board so that they affect alternate services as well as acute services, and
2. the cuts in active beds are made without consideration of the effect on remaining acute care facilities as well as on existing alternate services.

CNA would like to emphasize that reducing the number of hospital beds does not automatically result in better utilization. Similarly, curtailments of alternate services — home care for example — do not reduce costs.

Nurses have already made concrete suggestions about ways of responding to the needs: home care, use of the public health nurse, transportation services to ambulatory centers, homemakers, facilities for temporary placement of patients cared for in the homes, tapping of volunteer resources, drop-in centers, utilization of school buildings as health and social centers, etc. These are a few resources that could be expanded at a low cost, without creating a new network of expensive facilities and structures. We know that these services respond to real needs of people and would provide a good return for the health care dollar.

Large segments of population care needs can be met by nursing services. Acute care hospitals are not necessarily the ideal setting to meet these needs. Home care services offer definite advantages in terms of cost-effectiveness and support for the families.

Better use and availability of alternate services would prevent admission to acute care settings and would also help stop the " revolving door syndrome" of our system, where a patient is discharged only to be re-admitted for lack of support in the home or community. Without these services it becomes evident that a growing older population will continue to crowd acute care facilities.

What is needed is an unbiased assessment of these services in terms of their relative low cost, effectiveness and social importance. This will require a concerted and imaginative effort by the consumers of care, the health workers and government. Nurses are willing to enter such a partnership."





tandards for nursing education
draft document prepared by the Ad oc Committee to Develop Standards r Nursing Education will be esented at the next meeting of the oard of Directors.

This document will set forth a tionale for the preparation of andards, definitions of terms and atements on the various steps to be ken by educational institutions in the anning, implementation and valuation of nursing education rograms.

Accompanying this document will e recommendations regarding ways f obtaining feedback on the ocument from Canadian nurses; evision and/or modification of the ocument in the light of this feedback; nechanisms for circulating it and trategies intended to help educators nake use of the standards.

Members of this committee are osephine Flaherty (chairman), Helen Gemeroy (vice-chairman), Denise Dionne, Helen Glass and Judith Hibberd.

Special Committee on Nursing Research presents resolutions
n report to the Board, the Special Committee on Nursing Research resented recommendations on its ole, relationship with CNA's esearch and advisory services and CNA's role in the promotion of an rganization for nurse researchers.

Directors approved the following tatement of policy on research repared by the commitee:
. CNA shall use a variety of means nd resources to collect data in order o make decisions. CNA shall utilize esearch as one means of carrying out s mandate.
. CNA shall encourage the research ctivities of member associations, ndividual practitioners and education nd service agencies.
. CNA shall serve as a spokesman for he profession in relation to research in ealth services and promote the rticulation of nursing research with ther health care research.
. CNA shall utilize expert advice on olicies and activities related to esearch.

The Board of Directors accepted he committee's recommendation to ubmit a resolution proposing that CNA develop a policy statement on consumers' rights in health care using the Consumers' Association of Canada document, *Consumer Rights in Health Care*, as a beginning point for discussion.

The need for a social conscience
"We need to view rape, not from Victorian cocoons, but as we view any other assault," according to a *Brief on Rape* prepared by the Provincial Council of Women of Manitoba and presented to CNA Directors by MARN. (See *The Canadian Nurse* March 1976 p. 8)

Directors endorsed the brief and urged immediate action. As a result, letters and copies of the brief will be sent to CMA, CHA and other appropriate associations as well as member associations of CNA. CNA will also send the brief to the Minister of Justice and urge that recommendations contained in the brief be considered.

Definition of nursing practice and development of standards for nursing practice
In view of the commitment by members of the CNA Board, to develop a definition of nursing practice and develop standards for nursing practice, member associations have been asked to identify priorities among clinical areas requiring urgent attention. Responses were as follows: general medicine, general surgery, extended care, psychiatry, community nursing, emergency, rehabilitation and obstetrics. Member associations have also submitted names of nurse experts by clinical area, who may be called upon to work with the project director.

Further work on the project will continue following appointment of a project director. At that time, related ongoing work in CNA and member associations will be coordinated to assure the efficient completion of this project.

A resolution from the Board proposing continuation of this project will be presented for approval at the Annual Meeting and Convention in June.

Ad hoc committee to study Bill C68
Directors took several steps in response to Bill C68, "An Act to Amend the Medical Care Act," in relation to federal-provincial cost-sharing. They recommended that: 1. an ad hoc committee be struck to study the implications of Bill C68 on the nursing profession; 2. all member nurses' associations be sent a copy of the bill; 3. an open letter of concern be sent to the federal-provincial ministerial conference in April; and 4. CNA contact the CMA, CPHA, and CHA in order to develop a joint submission to the proposed bill.

Employment and unemployment problems
Directors of several member nurses' associations expressed concern that nurses were being denied unemployment insurance payments or were being asked to accept alternate employment. This appeared to be the result of variations in interpretation of the regulations by provincial and local officials.

Directors recommended that CNA inform the Unemployment Insurance Commission and Canada Manpower of problems that have arisen and ask these agencies to work in cooperation with member nurses' associations to find pertinent solutions.

Special interest groups
Margaret McLean, 2nd vice-president, reported to Directors on the desire of special interest groups to enter into a formal relationship with CNA. All member nurses' associations and most national nurses' associations were contacted by McLean during her survey.

To date, two member nurses' associations have made provision for liaison with special interest groups (RNABC and NBARN) and a third (AARN) is studying the matter. Two special interest organizations — the Canadian Association of Neurological and Neurosurgical Nurses and the National Committee of Nurse-Midwives have shown enthusiasm concerning a formal link with CNA.

CNA liaison
CNA continues to maintain a close liaison with allied agencies, organizations and associations. Several of CNA's liaison activities were discussed at the Feburary Board meeting.

The Canadian Council on Hospital Accreditation has invited CNA to appoint a second nurse representative to the Board of Directors commencing in 1977. Directors voted to accept the invitation.

The Girl Guides of Canada have asked that consideration be given to having registered nurses complete medical record forms for Guides leaving for camp. Directors agreed that the medical form should be revised in the format of a health assessment form to be completed by registered nurses. This proposal will be forwarded to the Girl Guides of Canada.

A request from ICN urged that a national association that sponsors the entry of another country into ICN develop a continuing relationship beyond the act of sponsorship. Directors agreed that CNA would meet this request within the limits of available resources.

The Canadian Division of the International Association of Enterostomal Therapists has requested CNA's viewpoint concerning the proposed practice of enterostomal therapists in Canada and recognition by the nursing profession. Directors will invite representatives to attend the CNA Annual Meeting when further discussion and evaluation can be sought. Other groups to be invited include the National Committee of Nurse-Midwives and the Canadian Association of Neurological and Neurosurgical Nurses.

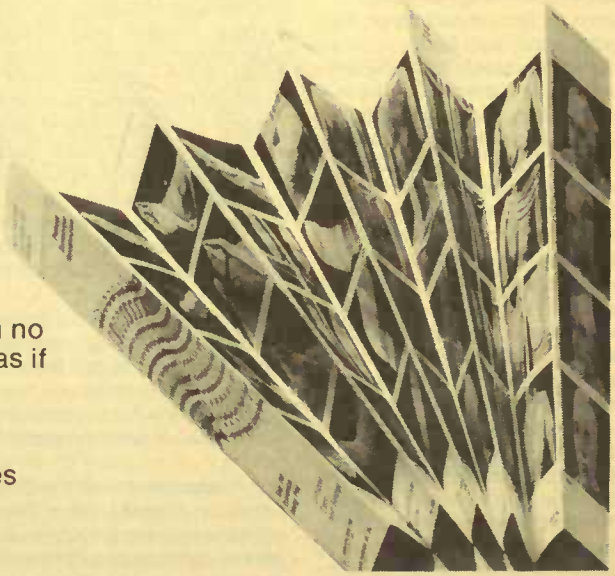
Instruction on common tropical diseases
CNA Board voted to support the intent of a resolution submitted by CPHA regarding instruction on common tropical diseases to all nursing students. CNA will encourage schools to integrate this subje curricula. The growing incic tropical disease in some r tion, Canada has been noted an ng 2 by public health nurses.

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News

RNANS publishes guide for roles

The Registered Nurses' Association of Nova Scotia has published a reference manual for practising nurses and educators to help clarify their roles in communicating with government, administrators and other health professionals.

"A Framework for the Practice of Nursing — Guidelines and Standards" was prepared by a special committee of the RNANS. It is dedicated to "those nurses who are contributing so much to improving health care in Nova Scotia during a difficult period of transition, to help them adjust to changing roles and expectations."

Work on the guide was completed by a group of nurses representing many areas of practice. It includes advice and comments from the general membership of RNANS and contains statements on: nursing obligations as a health service in the seventies; what constitutes nursing; the needs of individuals/families that can be met by the profession of nursing; nursing activities necessary for meeting needs of individuals/families; designation of the nursing activities to appropriate categories of nursing personnel, e.g. the baccalaureate nurse, the diploma nurse and the certified nursing assistant; nursing service standards that would facilitate nursing practice.

The RNANS points out that "the framework must not be considered final, but as a stage for further review" and hopes that it will be the basis for other projects, such as exploring the extended role of the nurse in Nova Scotia.

Bilingual Nursing School in New Brunswick

A new, nonintegrated bilingual institution, Ecole d'Infirmieres de Bathurst School of Nursing, will become the fifth school of nursing opened by the New Brunswick government since it began to phase out hospital schools several years ago.

The Bathurst school is scheduled to open its doors to 75 students next September. It will offer two separate diploma programs, one in English, the other in French. Director of the school will be Constance Morrison, former director of Chaleur General Hospital School of Nursing. Assistant director will be Sister Celine Doucet, a graduate of Hotel Dieu School of Nursing in Bathurst and the University of Montreal, who has been teaching community health at Université de Moncton and working at Foyer Notre Dame de Lourdes.

The only remaining hospital school of nursing in New Brunswick will graduate its final class this year. Four other schools with two-year programs (two English and two French) are now in operation.

Tips on bargaining

The link between collective bargaining and quality of nursing care must be recognized and understood by both the nursing profession and the general public, according to Toronto labor relations consultant, Dr. Eric G. Taylor.

Dr. Taylor was speaking at a workshop on collective bargaining sponsored by the Ontario Nurses' Association and held in Ottawa in February. The Ottawa meeting was one of seven similar workshops organized by the ONA and also held in London, Windsor, Toronto, Thunder Bay, Hamilton and Sudbury.

Dr. Taylor, who is resource person for the series, told Eastern Ontario nurses that their goal should be *relationship* bargaining rather than *adversary* bargaining which is always counter-productive and only results in loss of public sympathy for the group doing the bargaining.

He warned nurses at the workshop that the only way to successful negotiations is through effective planning. "You should decide on your priorities and then prepare a timetable." he said. "Then you should chart your plan of action as carefully as you prepare your patient records."

The Ontario Nurses' Association is a province-wide union set up two years ago with the assistance of the RNAO for the purpose of collective bargaining.

Students explore "Images of the Nurse"

Representatives from 20 university schools of nursing across Canada were in Kingston, Ontario, February 6,7, and 8 to attend the annual conference of the Canadian University Nursing Students Association, held this year at Queen's University.

CUNSA is a national organization for Canadian nursing students in baccalaureate programs. Their annual conference is aimed at promoting student interest in nursing activities, and gives members an opportunity to share their ideas and enthusiasm, and keep up-to-date with the latest advancements in nursing.





Photo by McIver

This year the theme of the conference was "Images of the Nurse," an attempt to answer an important question for students, "What can I do with my B.Sc.N. when I graduate?" An address by Elizabeth Logan, Professor of Nursing at McGill University, was followed by panel presentations on Nursing Specialties, Community Nursing, Northern Nursing, Nursing Education, Nursing Research and Nursing Administration. After the panel discussions, experienced nurses from the various nursing specialties were available for "Buzz Group" sessions.

A symposium on the Nurse Practitioner, held on Saturday morning, prompted many questions. Students asked if it were true that discrepancies in licensing across the country allow nurse practitioners in rural areas of some provinces to practice on their own, while a nurse practitioner with the same qualifications in another province is required to be affiliated with a physician. Questions were answered by a panel of five that included M. Callin, Director of the Family Practice Nurse Program at McMaster University, two nurse practitioners, a lawyer and a family physician.

At the CUNSA business meeting a new research committee was formed to promote and index CUNSA research. Also discussed were methods of encouraging liaison between CUNSA and CAUSN (Canadian Association of University Schools of Nursing) to promote the fulfillment of their common goals.

This year's conference was attended by 348 people and was funded jointly by the proceeds from student fund-raising projects, the Ontario ministry of health and the Registered Nurses' Association of Ontario (RNAO).

CUNSA was formed in 1970 to stimulate communication between nursing schools. By 1974 all of the 22 university schools of nursing were represented at the annual conference. Since then, the University of Montreal and Laval University have withdrawn to concentrate on the problems peculiar to nurses in Quebec. CUNSA hopes to regain their membership in the future.

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By Kathleen Newton Shafer, R.N., M.A.; Janet R. Sawyer, R.N., Ph.D.; Audrey M. McCluskey, R.N., M.A., Sc.M.Hyg.; Edna Lifgren Beck, R.N., M.A.; and Wilma J. Phipps, R.N., A.M.; with 28 contributors. 1975, 6th edition, 1,032 pages plus FM I-XVI, 8½" × 11", 608 illustrations. Price, $17.80.

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This valuable new guide provides a step-by-step approach to the clinical significance of laboratory tests. Unit I, Routine Multi-System Screening Panel, covers sequential multiple analyzer (SMA 12) tests, hematology screening panel and urinalysis. This is followed by an important table of potential variations of normal values that compares specific entities found in the routine screening process. Unit II describes in detail evaluative and diagnostic tests that should be used to confirm the diagnoses of abnormalities found in the routine screening panel.

arko M. Tilkian, M.D. and Mary H. Conover, R.N., B.S.N.Ed.
ber, 1975. 232 pages plus FM I-XVI, 6½" × 9½", 42
rations. Price, $7.90.

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NURSING MANAGEMENT OF RENAL PROBLEMS

A clear presentation of the physiologic and psychologic bases for nursing intervention, this unique text approaches nephrology as a vital subsystem of the whole body system. It offers in-depth discussions on normal and pathologic renal function; causes of renal disturbances; body responses and acute renal failure; medical therapy; and nursing intervention. Methods and processes of renal restoration are carefully detailed, with special attention to dialysis and transplantation and the psycho-social aspects of each.

By Dorothy J. Brundage, M.N. January, 1976. 204 pages plus FM I-X, 6½" × 9½", 20 illustrations. Price, $6.85.

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By Betty S. Bergersen, R.N., M.S., Ed.D.; in consultation with Andres Goth, M.D. February, 1976. 13th edition, 752 pages plus FM I-XIV, 8" × 10", 143 illustrations. Price, $13.60.

New 9th Edition!

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The most widely adopted anatomy and physiology text is now available in an updated new 9th edition. New features include: three chapters on the nervous system; new information on brain waves, consciousness, biofeedback training; expanded discussions on liver functions, reproduction, circulation, and much more!

By Catherine Parker Anthony, R.N., B.A., M.S.; with the collaboration of Norma Jane Kolthoff, R.N., B.S. 1975, 9th edition, 598 pages plus FM I-X, 8" × 10", 336 figures (145 in color), including 239 by Ernest W. Beck, and an insert on human anatomy containing 15 full-color, full-page color plates, with six in transparent Trans-Vision® (by Ernest W. Beck). Price, $13.95.

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An effective, self-teaching guide, this workbook relates basic mathematics to common solutions and dosages, and provides information essential for proper calculation, preparation, and administration of drugs. Updated throughout, material places more emphasis on the metric system and includes many new problems. The totally rewritten appendix contains drug standards and legal regulations; metric doses and apothecary equivalents; dosage rules for children; and more.

By Ellen M. Anderson, R.N., B.S., M.A. and Thora M. Vervoren, R.Ph., B.S. January, 1976. 10th edition, 168 pages plus FM I-VIII, 7¼" × 10½", 11 figures. Price, $6.60.

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Extensively revised and updated, the new edition of this popular text provides basic information and current knowledge on microbiology and pathology, both general and specialized. Informing your students of the latest scientific advances, the text features new discussions on: serologic diagnosis of protozoal and metazoal diseases, evaluation of cell-mediated immunity, immunotherapy, and more! A new unit on microbes, details on lab methods, and rules for specimen collection are also included. Review questions accompany each chapter.

By Alice Lorraine Smith, A.B., M.D., F.C.A.P., F.A.C.P. April, 1976. 11th edition, approx. 720 pages, 8" × 10", 563 illustrations, with 2 full page color plates. About $15.70.

New 3rd Edition!

THE FOUNDATIONS OF NURSING: As Conceived, Learned, and Practiced in Professional Nursing

Reflecting new dimensions in present day nursing, this updated text helps acquaint students with responsibilities, opportunities, and changes in professional nursing. Discussions focus on such timely topics as: patients' rights, nurses' rights, abortion, euthanasia, and health care delivery systems. New material examines death and dying, changes in nurse practice acts, transitional problems from student to practicing nurse, individual licensure vs. institutional licensure, and more!

By Lillian DeYoung, R.N., B.S.N.E., M.S., Ph.D.; with 3 contributors. April, 1976, 3rd edition, approx. 336 pages, 7" × 10", 14 photos, 29 illustrations. About $10.00.

critical care

New 2nd Edition!

A COMMONSENSE APPROACH TO CORONARY CARE: A Program

This important new 2nd edition reviews all major problems associated with acute myocardial infarction. Completely revised and expanded discussions cover anatomy, electrophysiology, chemical imbalances, complications, and more. New material discusses hemodynamic monitoring and drug therapy for shock and heart failure.

By Marielle Ortiz Vinsant, R.N., B.S.; Martha I. Spence, R.N., B.S., M.N.; and Dianne Chapell Hagen, R.N., B.S. October, 1975. 2nd edition, 228 pages plus FM I-XVI, 7" × 10", 439 original drawings by Marcellino Obaya. Price, $7.65.



New 2nd Edition!

NURSING CARE OF THE PATIENT WITH BURNS

Written by an experienced burn nurse-clinician, this text is a concise yet detailed resource for burn care, from first aid treatment to prolonged care of burn patients. Updated and expanded, it includes a new chapter on fluid therapy, and increased emphasis on pathophysiology, causes, and prevention of complications. It includes information on the importance of nutrition and special needs of young and older burn patients.

By Florence Greenhouse Jacoby, R.N. January, 1976. 2nd edition, 186 pages plus FM I-XII, 6½" × 9½", 18 illustrations including 2 color plates. Price, $7.30.

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This new guide is the first comprehensive text on continuous bedside hemodynamic monitoring. It provides current, detailed information for noninvasive and invasive monitoring of cardiovascular function — with special emphasis on the critical care setting. Each chapter includes a review of physiological principles and problem and solution tables.

By John Speer Schroeder, M.D. and Elaine Kiess Daily, R.N. February, 1976. 212 pages plus FM I-XII, 6½" × 9½", 137 illustrations. Price, $7.60.



behavioral science

A New Book!

CHRONIC ILLNESS AND THE QUALITY OF LIFE

This unique text delineates the psychological and social problems faced by patients afflicted with chronic disease, and offers specific information on how to help patients adjust to their condition. Topics include management of crises, family stress, handling of regimens, social isolation, and much more. Case studies clarify the principles presented.

By Anselm L. Strauss, Ph.D. June, 1975. 160 pages plus FM I-XIV, 6¾" × 9¾". Price, $6.05.

A New Book!

BEHAVIORAL METHODS FOR CHRONIC PAIN AND ILLNESS

Explaining the basics of behavioral analysis, this new text is the first to discuss control of pain by behavior modification techniques. Discussions present current information on: concepts of pain; how pain may become conditioned; methods for analysis of chronic pain; behavioral technology in relation to treatment planning; and treatment by behavioral techniques. It also provides important guidelines for the support nurses can offer patients' families.

By Wilbert E. Fordyce, Ph. D. February, 1976. 236 pages plus FM I-XI, 7" × 10", 31 illustrations. Price, $10.00.

A New Book!

BEHAVIOR AND HEALTH CARE: A Humanistic Helping Process

This new interdisciplinary text can help students understand the life-sustaining and life-enhancing aspects of health care. Perceptive discussions examine the problems that arise between patients and health care professionals. The authors define an advocacy model of human helping to aid students in coping with problems effectively.

By Jane E. Chapman, R.N., Ph.D. and Harry H. Chapman, Ph.D. October, 1975. 194 pages plus FM I-XII, 7" × 10". Price, $5.80.

issues and education

A New Book!

THE PROBLEM-ORIENTED SYSTEM IN NURSING, A Workbook

This first-of-its-kind workbook presents the problem-oriented system as a theoretical and practical basis for comprehensive health care. The authors provide a simple, effective approach that shows how to: collect data, identify patient problems, develop a plan for nursing care, and evaluate progress. Exercises are included to help students develop complete problem lists and write plans.

By Beth C. Vaughan-Wrobel, R.N., M.S. and Betty Henderson, R.N., M.N. February, 1976. 152 pages plus FM I-XII, 7¼" × 10½", 19 illustrations. Price, $6.85.

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By Jean E. Schweer, R.N., B.S., M.S. and Kristine M. Gebbie, R.N., M.N. January, 1976. 3rd edition, 216 pages plus FM I-VIII, 7" × 10", 3 illustrations. Price, $8.35.

current practice series

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CURRENT PRACTICE IN PEDIATRIC NURSING

This volume of original articles examines the broad spectrum of roles, theories, and tools of pediatric nursing today. It discusses the most current therapeutic strategies; specific family needs during fetal development and early childhood; nursing care of patients with special problems, and more.

Edited by Patricia A. Brandt, R.N., M.S.; Peggy L. Chinn, R.N., Ph.D.; and Mary Ellen Smith, R.N., M.S. February, 1976. 242 pages plus FM I-XIV, 6¾" × 9¾", 13 illustrations. Price: $11.05 (hard cover); $7.90 (paperback).

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Thought-provoking original articles and editorial commentary discuss trends, issues, and new perspectives in psychiatric nursing. Many diverse views and research findings are represented. Specific topics include: nurse-physician relationship in terms of the sexual stereotype; counseling the rape victim; social-psychological approaches to family mental health; and much more.

By Carol Ren Kneisl, R.N., M.S. and Holly Skodol Wilson, R.N., Ph.D.; with 24 contributors. February, 1976. 228 pages plus FM I-XIV, 6¾" × 9¾", 9 illustrations. Price: $11.05 (hard cover); $7.90 (paperback).

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CURRENT PRACTICE IN ONCOLOGIC NURSING

Outstanding contributors representing 14 cancer centers in seven states examine new nursing roles in cancer care — from detection clinic to terminal care at home. Topics cover: professional awareness; screening and early detection; therapy; maximizing the quality of life; and rehabilitation. The nursing process is emphasized throughout, with pertinent assessment guides preceding appropriate chapters.

Edited by Barbara Holz Peterson, R.N., M.S.N. and Carolyn Jo Kellogg, R.N., M.S.; with 26 contributors. February, 1976. 230 pages plus FM I-XVI, 6¾" × 9¾", 2 illustrations. Price: $11.05 (hard cover); $7.90 (paperback).

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Examining the dynamic changes and issues of modern nursing education, this new text focuses on *accountability.* Nationally known nursing educators contribute seventeen stimulating articles that encompass historical analyses and contemporary international perspectives. Timely articles include how to: prepare nurses for new, expanded roles while still filling traditional roles; meet growing health care needs while raising the level of education.

Edited by Janet A. Williamson, Ph.D., R.N.; with 18 contributors. February, 1976. 188 pages plus FM I-X, 6¾" × 9¾", 12 illustrations. Price: $11.05 (hardcover); $7.90 (paperback).



A New Book!

CURRENT PRACTICE IN OBSTETRIC AND GYNECOLOGIC NURSING

In this new volume, original articles cover contemporary issues and patient care in community and hospital settings. Specific topics include: psychological stress in the last three months of pregnancy; genetic counseling in maternity nursing; aspects of parenthood and the decision not to parent; abortion; and psychodynamics of the hysterectomy experience.

By Leota Kester McNall, R.N., M.S. and Janet Trask Galeener, R.N., M.S. February, 1976. 254 pages plus FM I-XVI, 6¾" × 9¾", 39 illustrations. Price: $11.05 (hardcover); $7.90 (paperback).

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News



Nurses across Canada can expect to hear more from their provincial associations about good health and fitness as a result of a two-day "Workshop on Fitness and Lifestyle" at CNA house February 20 - 21. In connection with CNA's health promotion project, representatives from all ten provinces and the Northwest Territories attended a training session that included participation in fitness tests and presentations on various aspects of fitness as a method of disease



prevention. Under the direction of Richard Lauzon and Mal Peepre Bishop from Recreation Canada, and Lynn Craig from the Non-Medical Use of Drugs Directorate, participants took part in and learned how to administer the Health Hazard Appraisal questionnaire and the Canadian Home Fitness Test (step test) in preparation for planning regional workshops.

With this experience and the aid of a grant from Recreation Canada, representatives will set up a health promotion program for nurses in their home-provinces in the coming year.

Presentations included talks on fitness and lifestyle, nutrition, and



fitness tests. In addition, representatives visited the Human Performance Laboratory at Ottawa University and took part in a water exercise program at Carleton University.

CNA's health promotion project is aimed at measuring the "health status" of individual nurses and assisting them to change their lifestyles in a way to promote better health.

Pictured doing the step test (from left to right) are: Brenda Kelleher, ARNN; Janet Lindquiest, Program Officer with the Department of Social Development, Northwest Territories; Peggy Bentley, RNANS; and Eleanor Trutwin, RNAO. Muriel Guarette (left) NBARN, and Dorenda Schoenhaels, SRNA, take their pulses after the step test, while Richard Lauzon looks on.

New CCHA guide

The Canadian Council on Hospital Accreditation has announced publication of *A Guide to Accreditation of Canadian Mental Health Services*. The Council describes the publication as "an essential guide to accreditation for psychiatric hospitals, mental evaluation centres and general hospitals with established services for mental health."

The new guide replaces *Standards for Accreditation of Mental Hospitals*. Copies are available from the Canadian Council on Hospital Accreditation, 25 Imperial Street, Toronto, Ontario, M5P 1C1. Cost is $8.50 per copy or $7.75 for five or more copies.

A French edition is expected to be available in the Spring of 1976.

Cardiac '76

Marielle Vinsant, clinical nursing teacher from Denver, Colorado, and co-author of "A Common Sense Approach to Coronary Care," will be one of the guest speakers at Cardiology '76, the third annual conference on cardiac care in Toronto in May. Dr. Ned Cassem, psychiatrist from the Massachusetts General Hospital in Boston, will give the keynote address on the psychological aspects of myocardial infarction. In addition to speeches and workshops, the program will include lectures, seminars, and discussion groups on current trends in treatment and care.

Information on the program, registration and accommodation, may be obtained from Conferences and Seminars Office, Humber College, P.O. Box 1900, Rexdale, Ontario.

At every convention there's someone who fears the chairman will call on him to speak. At the end of every convention there's someone who's irked because he wasn't called upon. Often it's the same person...

Frontier opportunity

Nurses who would like to work at a fly-in nursing station in a remote area of Canada, have until May 1st to apply for the 1976 Judy Hill Memorial Scholarship. The successful applicant will receive up to $3,500 to fund postgraduate nurse training with special emphasis on midwifery and nurse practitioner training.

The scholarship fund was set up in 1974 to honor Medical Services nurse, Judy Hill, who died as the result of a plane crash that occurred while she was escorting Eskimo patients from her nursing station to Yellowknife, NWT.

The scholarship is tenable in Canada, the United Kingdom, Australia and New Zealand. Applicants should be fluent in the English language, possess an RN diploma or equivalent, and be willing to work in the Canadian Arctic for a period of one year after completion of their postgraduate work.

The scholarship was won in 1975 by Beverley A. Robson, an employee of the Medical Services Branch of Health and Welfare Canada. Robson is now completing a program in midwifery in Edinburgh, Scotland. Applications for the current year should be submitted to Philip G.C. Ketchum, chairman, Board of Trustees, Judy Hill Memorial Fund, 829 Centennial Building, Edmonton, Alta.

CNF contribution

Money collected from professors and classmates of the late Judith Proctor (R.N., Vancouver General Hospital school of nursing; B.N., McGill University) has been given in her memory to the Canadian Nurses' Foundation. Proctor, an honors baccalaureate student in nursing administration, succumbed to a fatal illness last spring; her degree was awarded posthumously. Her professors and classmates chose to honor her memory this year by donating money to the Canadian Nurses' Foundation.

Applications for CNF scholarships for the 1976-77 academic year must be received by March 31st.

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"It was a year ago today," said Theresa's father as I sat visiting with them while they waited to see the surgeon. "I can't believe a year has gone by since the accident . . . ."

A Nursing Challenge: Replantation of a Severed Arm

Barbara Geyer



A year before, Theresa Bakx was a happy, normal two-year-old living on a farm with her parents and brothers. She enjoyed following her brothers into the fields but on this particular day had grown tired of trying to keep up and had decided to lie down in the hay to rest. Seconds later the hay mower severed her left arm at the elbow and severely lacerated her left leg.

When her father realized what had happened, he acted quickly and with remarkable presence of mind. He squeezed her upper arm as tightly as he could, and after several minutes succeeded in controlling the bleeding. He then picked up Theresa and her detached arm, and rushed to the house. He wrapped the arm in a towel and took her to the hospital in the nearby town of Rimbey. By that time the bleeding had stopped and arrangements were made immediately for an ambulance to take her to Edmonton, about 90 miles away.

In Emergency

Three hours after the accident Theresa was admitted to the Emergency Department at the University Hospital in Edmonton. She was conscious, her vital signs were stable, and she appeared to have withstood the ambulance trip very well. (Theresa's father remarked that during the trip she kept asking if the doctor would be able to fix her arm.)

In emergency, an I.V. of Ringers Lactate, to run at 60 ml/hr, was established in Theresa's right wrist. The stump was checked, cleansed with saline and rewrapped in a sterile towel. The detached arm was examined, cleansed, and placed in a sterile plastic bag with ice to preserve its viability. The large laceration on the anterior aspect of the lower left leg was also cleansed and dressed.

Following evaluation of Theresa's condition, a team of doctors decided to attempt a replantation of the left arm. Theresa met Malt and McKhann's classic criteria for replantation, parphrased as follows:[1]

— Is there a life-endangering injury involving the contralateral extremity?
— Is the amputated part in good condition?
— Are the nerves capable of regenerating and the muscles and tendons functioning?
— Is the amputation through the upper extremity?
— What is the patient's age?
— Are the resources of the hospital adequate to carry the patient through the long and tedious postoperative course?
— Does the patient actively desire replantation and is he likely to possess the psychological stamina for rehabilitation?

In considering these questions some particular factors weighed in Theresa's favor. If the amputation involves a lower extremity, replantation is rarely indicated, but replanted upper extremities are likely to be more functional than a prosthesis. Replantation is especially favored for children because they have a relatively shorter length of nerve to regenerate and they have more time available for rehabilitation.[2] In addition the Charles Camsell Hospital, where she was transferred for the operation, is equipped with facilities for a postoperative program, including progressive physiotherapy and occupational therapy departments and an active play program in the nursing unit.

Mr. Bakx was warned that several operations might be necessary if the replantation was attempted and that he and his wife would be required to participate in a long-term rehabilitation program for Theresa. He understood the implications of the operation and agreed with surgeons that a replantation should be attempted to restore the function in her arm.

Preoperative Care

Preoperative medical treatment included x-rays of the left stump, the left detached arm and the left leg. Hypertet (Tetanus Immune Globulin) 250 u., Tetanus Toxoid 0.5 ml and Penicillin G (Benzylpenicillin) 200,000 u. were administered to protect against clostridial and other infections. A Foley catheter No. 8 was inserted. A CBC, electrolytes, urinalysis and crossmatch for 3 units of blood were done. Theresa's vital signs remained stable. She was given nothing by mouth and was on hourly output.

O.R. Preparations

The two nurses on call for the Operating Room (O.R.) had only 45 minutes to prepare the theater and select and sterilize the instruments for the procedure. An R.N. who had previous experience in microsurgery in Australia selected the instruments,

many of which were normally used in orthopedic and eye surgery. A separate table was set for the debridement of the detached arm. The surgeons also requested an electric saw and a microscope. The microscope was to be used in the initial debridement and identification of the nerves and muscles, as well as in the actual replantation procedure. Several containers of normal saline were available for the debridement.

Since this was to be the first time this particular surgery was performed at Charles Camsell Hospital, the order of the procedure was not clearly defined. The two teams planned to work simultaneously on the debridement of the stump and the debridement of the detached arm. Following debridement and the pinning of the humerus, a separate table was to be set for use in repairing the laceration on the left leg.

Theresa was to be placed on the cardiac monitor and the anesthetist planned to make frequent checks of her temperature, pulse and respirations. While the O.R. was being prepared, the anesthetist talked to Theresa in simple terms about the anesthetic.

Surgical Procedure

The surgeons began with initial debridement of the proximal stump of the left arm. This included complete and careful removal of all foreign material (mostly hay from the mower), and irrigation with large amounts of saline. The patient was then prepped and draped, and further debridement of foreign material, necrotic muscle and bone fragments was done. The biceps and triceps tendons and the median, ulnar and radial nerves were identified and tagged for further repair. The brachial artery and its two veins were also identified.

Debridement of the distal stump was carried out in a similar manner on a separate table. The orthopedic surgeon then removed one inch of the distal end of the humerus so that the blood vessels could be repaired without tension; this would also ensure that an adequate length of peripheral nerve beyond the area of trauma would be available for suturing.[3]



Following the debridement, the patient was re-prepped and draped for the first step in the actual replantation procedure. The stumps were first matched as closely as possible; then the humerus was united by placing two K-wires 0.062 across the fracture site.

The plastic surgeons then proceeded with neurovascular repair, utilizing a recently developed neurovascular suturing technique. This method requires a skilled surgeon and, although slow, is the most reliable. The technique utilized 10-0 nylon suture, a special microvascular needle and microvascular clamps. The veins (brachial and cephalic) were repaired first to prevent blood loss from an unchanneled venous return.[4] Microvascular clamps were used so that the veins could be repaired without tension.

The brachial artery was anastomosed utilizing the same technique and circulation in the extremity was reinstated 9 hours and 15 minutes after the accident.

The next step was to suture the previously identified nerves. In this type of operation nerve repair can either be done during the first operation or left for a second operation. The advantages of *primary* nerve repair include simpler identification, no possibility of scar fixation, and prompt commencement of regeneration.[5] Particularly in a small child, the nerves are so tiny they are not readily identified, and may become locked in scar tissue if left for a second operation.

To prevent infection the devitalized soft tissue was debrided, ensuring that the vascular anastomoses were covered with only healthy, viable tissue.[6] The muscles were then approximated and the skin loosely closed. As there appeared to be a tightness in the forearm, an anterior compartment decompression was done through an S-shaped incision. The dressing on the arm was completed using Sofra-tulle* and a plaster slab. The elbow was maintained at approximately 90° flexion.

While the plastic surgeons were repairing the arm, the orthopedic surgeon repaired the laceration on the left leg. The leg was also debrided and irrigated, and the torn tendons were sutured. A short leg cast was applied.

Theresa's condition remained stable throughout the procedure. One hundred and sixty ml of whole blood, plus 480 ml of I.V. solution were infused through the cutdown site in the right ankle. Other medications administered during surgery included:

- Decadron (Dexamethasone) 4 mg, I.V.
- Aspirin (Acetylsalicylic Acid) supp. 10 rectally for anticoagulation
- Sodium Bicarbonate 25 mg, upon opening of artery
- Lasix (Turosemide) 10 mg, I.V.

Total time in the operating theater was 7 hours and 5 minutes.

Recovery Room

Theresa's condition was satisfactory on admission to the Recovery Room. Her vital signs were checked every 10 minutes and remained stable. Her catheter was draining amber urine.

Fifteen minutes after admission Theresa was conscious and responding. Frequent circulatory checks were carried out on both the left arm and leg; circulatory return was evident in the fingers of her left hand. The dressing was dry and intact. The toes of her left leg were pale but warm to touch.

Immediate Care on the Nursing Unit

Theresa arrived on the pediatric unit at 0350 hours. She was awake and responsive. Circulation to her left hand and foot was good. Her blood pressure was 96/64; respiration 28; apex beat 102; and temperature 37°. She was placed in a single room on separate technique.

During the next 12 hours Theresa was carefully observed for any change in her condition. Hourly checks included vital signs



*Sofra-tulle is a registered trademark of Roussel (Canada) Ltd.





ake and output and circulatory return. No dation was necessary until nine hours stop when she received Codeine lethylmorphine) 30 mg for discomfort in her t arm and fingers. A small amount of fresh nguineous oozing was apparent on the essing on her left arm. The dressing was inforced. Theresa slept following the algesic until her parents came to visit at 00 hours.

Postoperative Nursing Care

A nursing history was obtained from her arents during this first visit. Theresa was the ungest sibling, with three brothers aged 11, and 5 years. She ate well; fed herself table ods and particularly liked cereal, milk, juice nd tea. She occasionally had an afternoon ap and went to bed at 1900 — 2000 hours, llowing a bath. She was toilet trained.

Her immunization was up-to-date and she ad already had both measles and chicken px . She had no known allergies to food or edications. At present she had a "ringworm" ngal infection on her face.

When the nursing history and other vailable information had been gathered, ursing staff met for a conference to decide on a nursing care plan. Theresa's postoperative care was designed to meet the following nursing objectives:

- To prevent shock (a frequent complication following such a major injury) by checking her vital signs hourly during the first postop day, then once each shift
- To maintain fluid and electrolyte balance by accurate hourly measurement of her intake and output, by maintenance of I.V. sites, and by offering frequent sips of juice, milk or tea to encourage oral intake
- To prevent postoperative wound infection by checking and reinforcing the dressing, by administering I.V. antibiotics as ordered, and by placing Theresa on separate technique to reduce the risk of cross-infection
- To maintain adequate circulation in limbs by hourly circulatory checks and by ensuring that she received her A.S.A. as ordered (it was found that Theresa would take her pills if they were dissolved in tea)
- To prevent the formation of edema in the replanted limb by keeping her arm elevated above the atrial level at all times and by ensuring that the dressings were not compressing her arm
- To maintain the function of her left arm by positioning the arm with elbow at 90°flexion utilizing a plastic slab, and by passive flexion and extension of her fingers every hour
- To assist Theresa in expressing her feelings about the accident and to reduce the trauma caused by sudden hospitalization by providing quiet one-to-one play activities, reading stories, and allowing her to watch her usual T.V. programs. She spoke openly to the nursing staff about the accident and required frequent reassurance that the doctor had "fixed her arm."



Progress in Hospital

Theresa's hemoglobin was 7.7 g two days following surgery. She received 150 ml of packed cells and 60 ml of salt-free Albumin 25 percent. The Albumin was administered to maintain adequate circulation, draw fluid from the site of the injury, and prevent tissue edema.[7]

On her fourth postoperative day Theresa developed mild phlebitis in her right leg proximal to the cutdown site and the intravenous had to be moved to the left leg. The site of the phlebitis was then dressed. The same day she also had a brief cyanotic episode, possibly due to a mucous plug in her lung. She was placed in a croupette with oxygen for 24 hours.

Aside from these complications, Theresa recovered rapidly. On her fifth day she was up in a wheelchair and was socializing with the other children in the playroom. She celebrated her third birthday in hospital with her parents ten days following the accident.

The dressing on her arm was changed daily and her arm responded well to splinting and passive exercises. She returned to the O.R. for a split thickness skin graft to the incision on her left arm, and for removal of sutures in her left leg and application of a new below-knee cast.

One month after admission to hospital the graft dressing and the leg cast were removed. She began walking with assistance, but experienced difficulty due to foot drop. This was assisted by a pick-up splint. Most of her time was now spent in the Physiotherapy Department where she received passive movements to all joints in her fingers and hands. When she was out of bed, her arm was



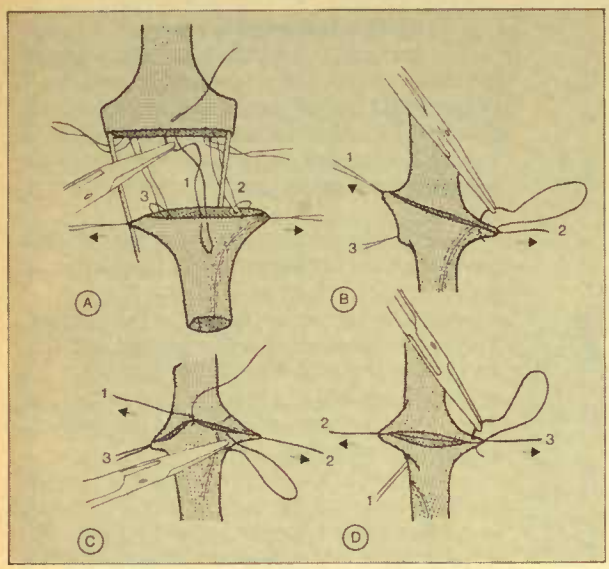


Fig. 1 — Example of venous anastomosis with running everted mattress stitch. In the lower vessel, two small veins have been joined to form a single large one.

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kept in a sling except for short play periods to encourage active elbow movements. To strengthen her left leg she rode a tricycle.

Theresa's parents and brothers visited as often as possible. Prior to her discharge her parents were instructed regarding her care at home. They were taught to do daily passive movements of all joints in her elbow and hand, as well as daily massaging of the scar on her forearm. Theresa was to have two hour-long play sessions each day without her sling to encourage active movements of her elbow and fingers. Her parents were warned about the lack of sensation in her arm and hand, particularly to hot and cold temperatures.

Although there was a public health nurse in Rimbey, Theresa's parents were strongly motivated to carry out this part of the treatment on their own. An appointment was made for Theresa and her parents to return to the hospital in ten days.

Follow-Up

On their first visit, the physiotherapist and the occupational therapist found that Theresa's parents seemed to be managing well at home. She appeared to have active movement of her arm using her biceps and triceps. The skin across the front of her elbow was tight and she complained of pain in this area when her fingers were massaged. She could passively extend her fingers, but her thumb opposition and index and middle fingers were still tight. Her parents were encouraged to continue, and one week later they proudly reported that Theresa had begun to actively move her fingers.

One month later, Theresa appeared to have good wrist extension and she could flex and extend her elbow actively. There was still a slight tightness in her index and middle fingers. Theresa continued to visit the hospital monthly. A new splint was made by the occupational therapist, and with it her fingers became more supple. All her active movements increased in range and strength. She appeared to have sensation in her hand, although this was difficult to test.

Eight months following the accident Theresa had active wrist flexion and extension. She could pinch using her thumb and all her fingers.

On July 15, 1975, exactly one year after the accident, Theresa was using her arm functionally. Examination by the physiotherapist showed the following:

- shoulder — full range of motion
- elbow — extension 15°; flexion 115°
- forearm — pronation — full range of motion; supernation — 15°
- wrist — active — extension 5°; flexion 45° with no active radial or ulnar deviation
- fingers — flexors tight — difficult to extend if wrist in extension
- space from tip of thumb to tip of index fingers measured 5" in right hand; 4 1/2" in left hand

On the occasion of her follow-up visit one yea after the accident, I had the opportunity to vis with Theresa and her father while they wer waiting in the doctor's office.

Although she is a quiet girl, Theresa answered my questions about her arm and was happy to show me what she could do. A one point, I offered her a lifesaver; she took i and, using both hands, opened the packag and helped herself to one.

Theresa spoke positively of her experience in the hospital. During earlier follow-up examinations she had gone back t the ward to visit, and this time still asked abou the other children on the ward.

Theresa now has good function of her le arm. She can lift well, and can dress hersel though she still has some problems with buttons. She plays actively outdoors except i extremely cold weather, but does protect he arm when falling or being bumped. Her fathe feels she has adjusted well to her replante arm and is optimistic about the future.

Barbara Geyer (R.N., University of Alberta Hospital School of Nursing; B.Sc., Universit of Alberta) was Pediatric/Obstetric Supervisor at the Charles Camsell Hospital i Edmonton at the time of the replantation.

The author wishes to thank Dr. Lobay, who performed the surgery; Jean Newman, Director of Nursing; and the nursing staff in th O.R. and on nursing station 32A at the Charle Camsell Hospital for their suggestions and support while writing the article.

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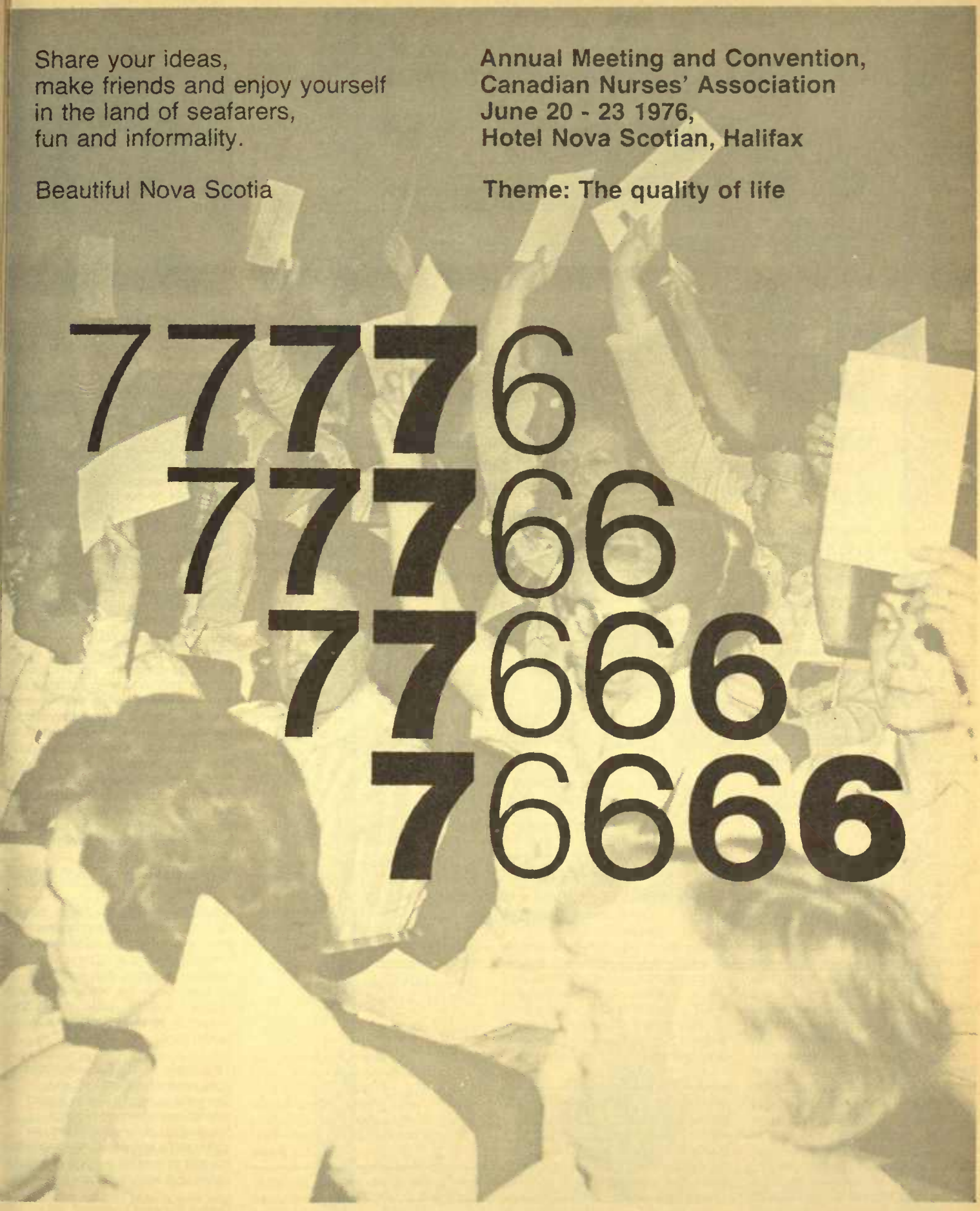
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Canadian Nurses' Association

Ticket of nominations
1976-78 Mandate

President elect: (1 to be elected)	Alice Baumgart
Vice-presidents: (2 to be elected)	Margaret McLean Sheila O'Neill Shirley Stinson
Member-at-large, nursing administration: (1 to be elected)	Marguerite Bicknell Marion Jackson Brenda Kelleher Barbara Racine
Member-at-large, nursing education: (1 to be elected)	Lisette Arcand Myrtle Crawford Helen Glass Marilyn Marsh Margaret Page Joanne Scholdra
Member-at-large, nursing practice: (1 to be elected)	Lorine Besel Elizabeth Greene Judith Hindle Dorothy Pringle Therese Schnurr Vera Spencer
Member-at-large, social and economic welfare: (1 to be elected)	Margaret Bentley Linda Gosselin Anne Toupin

President



Joan M. Gilchrist B.N., M.Sc., (McGill)

Present Position:
Professor and Director, School of Nursing, McGill University, Montreal.

Association Activities:
CNA— president-elect (1974-76), presently member of special committee on nursing research; CAUSN — member of Council of Deans and Directors, chairman of committee on structure; discussant, national conference on nursing research, Edmonton, Alberta (1975); tutor, Health Care Evaluation Seminar at Dalhousie U. (1974); discussant, National Colloquium on Nursing Research at McGill U. (1973); formerly active in ANPQ; has published numerous articles and papers and given many addresses.

The role of an organized profession in health care today is multifaceted. It makes decisions and takes action relevant to many spheres of responsibility. In general, however, its concern is to provide the framework within which desirable changes are identified, innovative structures for their attainment are evolved, and individuals are prepared and motivated to carry out responsive and goal-oriented actions.

Crucial in shaping this role in nursing as a collectivity is the articulation of one central principle upon which national policies are predicated. This principle is simply that nursing is accountable to the people of Canada and is, therefore, responsive to the human need of all Canadians for health care.

To achieve health services that are comprehensive in nature and universal in reach, and to exploit educational structures for the preparation of new members, an ability and a willingness are needed on the part of nursing leaders to acquire vision and accept risk.

During the past biennium, your Association has embarked upon a broad program incorporating a

umber of activities and projects of entral concern to Canadian nurses nd nursing. These comprise, for xample, a comprehensive xamination for licensing, including an ssessment of the performance of ew graduates, a study of nurses ractising in an extended role, tandards of nursing practice and ursing education; however, the atients' bill of rights remains to be ompleted. In addition, we must now ake the initiative in responding to the eeds and interests of members. This ould entail promoting significant esearch in nursing and in assuring a ursing presence in all situations here decisions affecting nursing and ealth care delivery are made.

Candidate: President Elect



Alice Jean Baumgart, B.S.N. (U. of British Columbia), M.Sc. (McGill)

Present Position:
Graduate Student, Department of Behavioural Sciences, Faculty of Medicine, U. of Toronto. Associate Professor, School of Nursing, University of British Columbia. (On sabbatical leave since Sept. 1973).

Association Activities:
RNABC — chairman-joint committee on the expanded role of the nurse in the provision of health care (1972-73), second vice-president (1969-71); CNA — member of ad hoc committee on testing (1973-4), — chairman of committee on nursing education (1970 -72), member of CMA/CNA joint committee on the expanded role of the nurse, member of special ad hoc committee on testing service, formerly member of board of directors and executive committee, formerly member of CNA/CHA joint committee for extension course in nursing unit administration; Canadian Conference of University Schools of Nursing — president (1968-70); member of various committees concerned with the planning of the Health Sciences Centre (U.B.C.); author of numerous articles for *The Canadian Nurse* and other health-related publications and many addresses to professional groups.

The continued growth of nursing associations in Canada over the next few years, indeed their very survival, requires a renewed sense of purpose and vitality. First and foremost, this calls for imaginative thinking and action to improve and defend the practice of nursing. Organizations such as CNA must be in the forefront in monitoring the quality and efficiency of nursing services. They must lead the way in promoting research on patient care. They must involve themselves in improving the methods, techniques and systems of nursing practice. They must bear the burden of proof that nursing is an essential public service.

I believe that it is also time for CNA to come to grips with how the practice of nursing can be made more satisfying or rewarding. Past approaches to dealing with the frustration, turmoil and futility felt by so many practising nurses have proven to be failures. New mechanisms are needed to capture the enthusiasm and support of our members and help them feel a professional commitment to improving the health care of Canadians.

Candidates: Vice-president



Margaret D. McLean, B.Sc.N. (U. of Western Ontario), M.A. (Columbia U.), post-master's study in administration of schools of nursing and of nursing service.

Present Position:
Director and professor — Memorial U. of Newfoundland School of Nursing, John's.

Association Activities:
CNA — 2nd vice-president (1974 - 76), (1968 - 70), chairman of committee on nursing service (1966 - 70) and member of many other committees at national and provincial levels.

"I believe the profession of nursing has a great opportunity to make its optimum contribution to the well-being of individuals, families, and communities. Nurses have said they are responsive to the health needs of people. We must really be so now if nursing is to achieve its potential in the health care system. This will necessitate great changes, but the time is ripe for the organized profession to respond to the health needs of the people in helpful ways, to demonstrate what excellence in expanded nursing practice can do, and to work in colleagueship with other health professionals and consumers in the promotion, retention, attainment, and restoration of health and well-being."

This is what I believed two years ago and it is my belief today.
In the current biennium we have made a beginning in the development of standards and criteria for evaluation of practice. There is much to be done yet but we are really on the way. It is an exciting time for CNA and the provincial associations.

I have accepted nomination as vice-president because I believe in people, in nurses, in nursing, and that, by working together in CNA we will achieve our optimum potential.



Sheila O'Neill, B.N. (McGill), completing M.Sc. in nursing at McGill University.

Present Position:
Nursing Director, Medical Pavilion, Royal Victoria Hospital, Montreal

Association Activities:
ONQ — first vice-president (4 yrs) and member of Bureau (6 yrs), member of task forces on Bill 65, Bills 250 and 273, co-chairman of professional services committee, member of committee on quality of care; CNA — member of board of directors as non-voting observer (3 yrs), member of committee on social and economic welfare.

When colleagues asked me to be a candidate for election to the Board of CNA, I accepted because I believe it is important to the further development of nursing in Canada that there continue to be a forum where nurses from across the country may meet to discuss mutual concerns and share ideas about where the organized profession should be going. It is by continued strong representation at the national level that we as a group may participate in the development of governmental policies and programs that directly or indirectly influence health care systems at the provincial level.

I do not believe that any organization, especially in these days of budgetary restraint, can be all things to all people simultaneously. If I am elected, I will do my best to help articulate the needs perceived by the nursing profession, and particpate in the establishment of priorities and the search for solutions.



Shirley M. Stinson, B.Sc. (U. of Alberta), M.N. (U. of Minnesota), Ed. D. (Columbia U.)

Present Position:
Professor, School of Nursing and Division of Health Services Administration, and Graduate Program Coordinator, U. of Alberta, Edmonton.

Association Activities:
CNA — member-at-large for nursing education (1974 - 76), chairman and then member of the special committee on nursing research (1971 - 75), member of steering committee on the development of a definition of nursing practice and development of standards for nursing practice (1975); project director for the 1975 National Conference on Nursing Research; member of the Health Industry Committee of the Economic Council of Canada; has served on several committees related to health services and the expanding role of the nurse; and has given numerous addresses and consultations.

National nursing organizations, like other large bureaucracies, tend to become self-satisfied, inbred, and inflexible. In my view, one of the best antidotes if not cures for this kind of organizational disease lies in electing representatives who are attuned to the realities of nursing and the health care field, who can look at the scene critically and who can come up with practical solutions. As a CNA Vice-President, I would try, to the best of my ability, to be this kind of antidote.

Candidates: Member-at-large, Nursing Administration



M. Marguerite Bicknell, B.N. (McGill), M.S.H.A. (U. of Alberta)

Present Position:
Assistant Executive Director of Nursing, Brandon General Hospital, Brandon, Man.

Association Activities:
MARN — chairman of legislation committee (1974 - 76), member of board of directors (1970 - 71); member of Canadian College of Health Services Executives.

In the developing health care systems, the traditional emphasis on illness has been replaced by a broader focus on health promotion and maintenance. Nursing, as the largest of the health professional groups, has a critical role to play within the context of this new health perspective.

My acceptance of this nomination for member-at-large nursing administration, is based on the belief that nurse administrators, as facilitators of change, must play a key role in effecting these changes at all levels of decision making. Further, I believe that our national professional body, the Canadian Nurses' Association, assumes a prime leadership role in advancing the cause of nursing in the developing health care systems. The key is unity, therein lies the strength.

For these reasons, I would consider it a privilege to serve on the Board of Directors, CNA at this crucial time.



Marion Ruth Jackson, B.Sc.N. (U. of Saskatchewan), M.S.N. (U. of British Columbia)

Present Position:
Assistant Executive Director, Saskatoon City Hospital, Saskatoon, Sask.

Association Activites:
SRNA — Presently member of standing committee for registration and admission to membership and chairman of committee for approval of nursing education programs in Saskatchewan, past member of board of examiners (1968-71), chairman of subcommittee on publicity and information for the 1968 biennium in Saskatoon; member of Saskatchewan Association of Hospital Administrators (1975); affiliate member of Canadian College of Health Services Executives (1975); field representative for the CCHA (1974); author of many articles published in *The Canadian Nurse*.

The approach to Nursing Administration must follow from one's basic philosophy of nursing. Further to this, the successful nurse administrator must depend on continual feedback from the general duty staff nurses, head nurses and nursing supervisors. These are the nurses who determine the standard of care given to the patient. I believe the nurse administrator assists and coordinates the setting of standards of care, and should provide the optimum environment and leadership to attain high standards, but will achieve this only through free dialogue with all members of the nursing staff.

In accepting this nomination, I would work diligently to encourage health care agencies to press provincial and federal governments for increased funding for nursing personnel which would provide for improved orientation and continuing education programs for the practicing nurse. It is my belief that many of our beginning nurse practitioners are placed in impossible work situations. This has been explained by some nurses as "impoverished work situation, heavy patient work load, unable to give optimal care, frustration because they cannot give the kind of care they were taught to give." There is a gap between the beginning practitioner and the practicing nurse who is able to take the knowledge she has learned and combine it with the psycho-motor skills she has gained in order to make sound nursing judgments. I would also encourage health care agencies to recognize the nurse administrator as a vital member of the administrative team, equally as important as the Medical Director, Finance Director and such other administrative positions that may exist.



Brenda Kelleher, B.Sc.N. (U. of Windsor), M.Ed. (Adm.), (Memorial U. of Newfoundland)

Present Position:
Systems Analyst, Waterford Hospital, St. John's, Nfld.

Association Activities:
ARNN — chapter president for the past two years,

I believe that the ultimate goals of nursing service include the prevention of disease where possible and/or care of the patient from the moment of sickness until cure and/or optimal rehabilitation. In order to achieve these goals,the role of nursing service administration is to ensure the provision of continuous individualized service to the patient, both physically and psychologically. The absence of a knowledge of administration results in confusion of responsibilities, and the dispersion of authority. This leads to the wasting of resources, low morale and the defeat of expected levels of patient care.



Barbara Ann Racine, B.Sc., M.S.H.A. (U.of Alberta)

Present Position:
Assistant Executive Director, Nursing Practice, Royal Columbian Hospital, New Westminster, B.C.

Association Activities:
CNA — member of special committee on nursing education (1973); CNF — member of selection committee (1972 - 74); Victorian Order of Nurses, member of board of directors (1973 - 74); AARN — member of ad hoc committee on long range planning (1972 - 74), provincial council (1972 - 73); Chairman of north central district executive (1972 - 73); CAUSN — member of executive for Edmonton chapter of Western Region (1972 - 73); associate member of Canadian College of Health Services Executives (1975); has given numerous addresses to health workers.

I believe that nursing has a unique role in providing and promoting efficient and effective health care services. The challenge of nursing administration is to provide an environment in which nurses may function and to assess, plan, implement and evaluate the processes or ways in which health care could, should, and will be delivered, all the time working with the individual nurses in developing attitudes that are conducive to high quality care.

Candidates: Member-at-large, Nursing Education



Lisette Arcand, M.N. (U. of Montreal)

Present position:
Director of continuing education programs for nurses at the Extension Division and Assistant Professor at the School of Nursing Sciences, Laval University, Quebec City.

Association Activities:
ONQ during the past five years, member of the following committees: committee on research and development on nursing, committee on nursing care and subcommittee of public health and home care nurses, committee on schools of nursing, committee on continuing education (president 1975-76), numerous ad hoc committees concerning a plan for nursing education in Quebec, reports such as *Operation Sciences de la Santé, Le College* and others; Laval University — committee on continuing education, committee on family medicine, president of the committee responsible for admission to the Certificate in nursing (extension), president of committee on nursing program, president of multidisciplinary steering committee for the Certificate in nursing (extension), president of evaluation committee for demonstration projects in health education to the population, member of board of directors of the school of nursing sciences; federal government — member of national committee on health manpower; has published many documents and given numerous conferences.



Myrtle Evangeline Crawford, B.S.N. (U. of Saskatchewan), M.A. (Columbia U.)

Present Position:
Professor of Nursing and Assistant Dean, College of Nursing, U. of Saskatchewan, Saskatoon.

Association Activities:
Member — Board of Nursing Education — Saskatchewan (1973 -); CNA — member of board of directors (1963 - 65), formerly a member of committees on nursing education, school improvement program, nursing affairs and committee to study the task force report on health services; SRNA — past-president (1965 - 67), president CNA (1963 - 65), 1st vice-president (1962 - 65).

I have accepted this nomination because I believe that I have a good background of experience to bring to discussions that deal with current nursing issues. The Canadian Nurses' Association as the voice of the largest body of nurses in Canada should be speaking out on some of these issues.

My major experience and knowledge is in the field of nursing education but it is not my only concern. I am aware the education of practitioners is only relevant if it is in close touch with the realities of the service situations in which the practitioners will be working.

I would look forward to participating in the discussion of nursing issues at a national level.



Helen Preston Glass, R.N., (Royal Victoria Hospital, Montreal, Que.) B.S. M.A., M.Ed., Ed.D. (Columbia U.)

Present Position:
Director, School of Nursing, U. of Manitoba, Winnipeg, Man.

Association Activities:
MARN — chairman of committee to prepare a position paper on nursing education (1974), chairman of ad hoc committee on nursing research, (1971), president, member of board of directors (1966 - 68), chairman of ad hoc committee on the development of nursing education in Manitoba (1963-68), formerly chairman of committee on accreditation, education, careers; CNA — member of ad hoc steering committee for the development of a definition of nursing practice and development of standards for nursing practice (1975 —), member of special committee on nursing research (1970), member of board of directors (1966 - 68), member of subcommittee on nursing education (1964 - 66).

It is my belief that nursing stands on the threshold of its greatest contribution to society, provided we recognize the necessity of a sound educational base for nursing. In keeping with the movement from illness and cure orientation to illness prevention and the promotion of health for all Canadians, nursing education at all levels must prepare practitioners capable of assisting individuals and families to attain health and to prevent the depletion of a healthy state in all circumstances. Nursing education must concern itself with setting new goals, and the means of achieving these in society. This includes enabling practitioners to develop social and political skills that will be effective in bringing about change and credibility with the public through superior service. The foundation for this is educational strategies developed in conjunction with nursing service, and with other health and service professions.

As member-at-large for nursing education, I would work toward a reduction of ad hoc programs preparing a variety of types of practitioners; concentration on the development of diploma and baccalaureate nurses; the development of graduate education; and continuing education at all levels. I would encourage the development of improved programs for teachers of nursing, giving equal attention to adequate funding for their preparation. I would strive toward process-oriented curricula based upon health-nursing models, with emphasis on the process of nursing based on a solid research foundation. I would also encourage the development of educational standards which would ensure our accountability to the public and to the student through responsive evaluation, so that we may know how well we are serving both of these groups.

I believe that with my background of preparation, my involvement with many committees of the Canadian Nurses' Association, the Canadian Association of University Schools of Nursing, the Manitoba Association of Registered Nurses and other associations concerned with education and health care, I will be able to serve effectively, the nurses of Canada.



Marilyn Marsh, B.N. (Memorial U. of Newfoundland), currently studying towards master's degree in education.

Present Position:
Lecturer, School of Nursing, Memorial U. of Newfoundland, St. John's.

Association Activities:
ARNN — formerly 1st vice-president, 2nd vice-president, treasurer, served on many ad hoc committees; worked on committees to prepare briefs, i.e. Miller Report, Hall Report; Memorial U. representative to ICN in Mexico.

I have accepted nomination for the position of member-at-large representing nursing education

because I feel that nursing, along with other professions is moving into a new era of rapidly expanding knowledge that places new demands on its practitioners. Consequently, professional groups are requiring their practitioners to keep their knowledge and skills up-to-date.

In addition to this, nurses must be better prepared to research their field so that a data base can be secured for nursing practice. Nurses must be able to give quality nursing care in collaboration with others in the health field.

Indeed, a commitment to lifelong learning is the mark of the truly professional person. Therefore, I would like to be involved in nursing education for the future.



Margaret Ruth Page, B.Sc.N., (Lakehead U.), M.P.H. (U. of North Carolina)

Present Position: Associate Professor, Lakehead University, School of Nursing, Thunder Bay, Ont.

Association Activities:
RNAO — member of advisory committee to the president (1975), member of planning committee for conference entitled Collaboration for Change (1975), past president (1964-65); CAUSN — member of committee on constitution and bylaws (1973 -); Ontario Council of Health — member of subcommittee on nursing education (1967 -70); College of Nurses of Ontario — member of educational advisory committee (1965 - 68); CNA — member of socio-economic committee (1965 - 66), member of board of directors (1964 - 65).

Nursing education is responsible for preparing practitioners who can function in a health care system buffeted by social change. Hence the Canadian Nurses' Association must be attuned to the political climate, to the demands of society for well prepared nurses in a variety of nursing programs; this includes nurses with technical expertise, generalist preparation and clinical specialization.

Incorporated into all the programs must be the incentive for the development of characteristics such as creative thinking, flexibility and inventiveness. To ensure the practitioner the competencies to practice and function in a collegial fashion with the other members of the health team a sound base of scientific knowledge and skills is a prerequisite.

The current changes also demand that efforts be directed in intensified programs for continuing education for professional nurses, interdisciplinary learning opportunities and greater involvement with service personnel in the educational process.

We must constantly be aware of the cost of education and health care and tailor our nursing program accordingly, in order not to sacrifice excellence and quality for the learners.

It is my belief that the Canadian Nurses' Association has a responsibility for stimulating new concepts and supporting research in nursing education; improving working relationships within the nursing community, externally with public and private organizations, of citizens, and of other professional practitioners who are concerned about the quality of health care for the people of Canada



Joanne Dolores Scholdra, B.S.N. (U. of Saskatchewan), M.N., Ph.D. (U. of Washington).

Present Position:
Chairman, School of Health Services, Lethbridge Community College, Lethbridge, Alta.

Association Activities:
AARN — member of nursing education/ nursing practice committee (1975 - 76), member of nursing research committee (1976), chairman of provincial nursing education committee (1967 - 68); member of Alberta task force on nursing education (1975 —); University of Alberta — member of advisory committee, department of continuing education (nursing division); (1974); University of Alberta Co-ordinating Council — member of nursing education committee (1974); member of the Alberta task force on nursing education (1975).

The planning, implementation and evaluation of nursing and health care is a process which can be learned during the basic nursing program and subsequently deepened and enriched as the nursing practitioner takes part in orientation, in-service, continuing education, and graduate programs. This growth and enrichment presupposes motivation and the availability of formal and informal programs to increase the level of competency of nurses throughout their working lives.

In view of the explosion of knowledge, the complexity of man's health problems, the increased expectations of the consumer of health services, and the development of various health-care delivery systems, it becomes apparent that the future health care professional requires a broad educational base and an armament of fairly sophisticated skills. Recognizing the need for depth and breadth of knowledge and expertise it is my belief that baccalaureate preparation for all professional nursing practitioners must become the base and the goal to assure continued professional growth and improved nursing practice.

To this end the Canadian Nurses' Association and provincial nursing associations will be required to provide increasing leadership to government departments and associations responsible for post-secondary education and the setting and monitoring of educational standards in nursing. Through the development of nursing practice and nursing education standards and the ultimate development of a national accreditation system, the CNA would promote a gradual adjustment of the system to the increased educational requirements.

The nursing practitioners of the future must take their place amongst health care professionals whose minimum professional preparation is at least a baccalaureate degree.

Candidates: Member-at-large, Nursing Practice



Lorine Besel, B.N., (McGill) M.S. (U. of Boston)

Present Position:
Director of Nursing, Royal Victoria Hospital, Montreal, and Assistant Professor, McGill University, School of Nursing, Montreal.

Association Activities:
CNA member-at-large for nursing practice, member of ad hoc steering committee on development of a definition of nursing practice and development of standards of nursing practice, member of ad hoc committee on standards for nursing care (1970 - 72) represented CNA on national committee of mental health professions (1972), member of ad hoc committee on standards for nursing service (1966 - 70); ONQ member of advisory committee to board of management (1971 -).

I have agreed to be nominated for the position member-at-large — nursing practice — for the CNA Executive Committee of the Board.
Nurses, as individuals and as a professional group, appear to be facing many contradictory pressures and pulls: specialization and narrowed expertise versus generalization and broad knowledge base, illness versus health focus, expanded nursing role versus restricted resources. Can we be all things to everybody?



Elizabeth E. Greene, R.N. (General Hospital School of Nursing, St. John's, Nfld.)

Present Position:
C.C.U. Supervisor, General Hospital, St. John's, Nfld.

Association Activities:
ARNN — presently member of education committee, restructuring committee (1975), nominating committee (1975), member of council (1974 - 76); Newfoundland TB and RD Association — presently member of board of directors, past-president of nurses section (1974 - 76); Newfoundland Heart Foundation — presently member of board of directors; Canadian TB and RD Association — advisory committee, chairman of planning committee to set up a one-week course in RD nursing for Eastern Canada.

I accept the nomination for member-at-large, nursing practice because I am concerned for the total care of our patients, their families, and for the nurses giving that care.

I believe that the nursing profession must concentrate, not only on the patterns of education, but on the changing patterns of nursing practice. As research brings about more sophisticated medical treatment, so must the practicing nurse be prepared to adapt in order to help make this highly technical type of treatment more effective and successful.

I believe that continued evaluation of ourselves, our nursing procedures and our responsibilities are essential for better patient care. That we as nurses must work as a member of a health care team, not merely to carry out doctors orders, but assisting doctors in carrying out their own orders and treatments.



Judith Karen Hindle, B.Sc.N., B.A., (U. of Toronto)

Present Position:
Currently studying towards M.A. at U. of Toronto.

Association Activities: RNAO — active member, 50th anniversary RNAO fellowship for graduate study; the Canadian Council of Cardiovascular Nurses — Ontario provincial respresentative to the public education committee.

Much discussion in recent years has centered on the effects of change in the nursing profession in this country. In many areas of nursing practice these changes have unfortunately been viewed in largely negative terms. Here, deteriorating practice conditions, pessimism about the future of both education and practice, and expressions of individual powerlessness and loss of control punctuate conversations among nurses at many levels. The continuing attrition from nursing practice of productive, talented and once enthusiastic colleagues who have decided to opt out, rather than continue to "struggle with the system" seems to further threaten the possibility of improving the quality of what we do.

The Canadian Nurses' Association, through its provincial representatives and members-at-large, is an obvious and important vehicle for collective action. I believe its current projects, directed at the study of human resources in nursing practice, at evaluation of practice, and at research in practice, are particularly important in planning for changes that will occur in nursing practice in the next several years. I also believe its leadership role in predicting, promoting and guiding change in nursing, generally, is more important now than at any other point in our history. If I am elected as member-at-large for nursing practice, I would regard it a privilege, a pleasure and a responsibility to participate in that process.



Dorothy May Pringle, B.Sc.N. (McMaster U.), M.S. (U. of Colorado)

Present Position:
Director, Laurentian University School of Nursing, Sudbury, Ont.

Association Activities:
Active member of RNAO, AARN, and Canadian Psychiatric Association.

Improving the quality of nursing care to patients and the satisfaction of clinical nursing to nurses should be the ultimate and mutual goals of both nursing service and nursing education. Chronically frustrated nurses cannot be expected to provide nursing care of which they can be proud, nor to act as role models for students to emulate. Yet clinical nursing is where the action is and where the satisfaction is for most nurses. Unfortunately, the daily demands of this action frequently preclude clinical nurses from having the time and opportunity to develop a long-range perspective on their role, and from influencing where nursing is going.

Education, on the other hand, tends to have the long-term perspective but misses the day-to-day clinical demands and timing. This can result in education being irrelevant and unhelpful when it comes to responding to the immediate needs of the clinician but it does put educators in a position to influence trends.

As the fiscal situation deteriorates, both education and service will be forced to work more efficiently and to separate essentials from luxury.

Neither the clinician nor the educator can afford to operate in isolation from the other, but the mechanism for bringing the immediate and the long-range views together for the mutual benefit of both is less than satisfactory in most places. Marlene Kramer has identified the damaging effect this can have on new graduates and ultimately on nursing as a whole.

As nursing evolved, service and education started as one, then separated to become two quite distinct entities and now the need and the opportunity exist to create a new relationship that is based on colleagueship. This is essential, if nursing as we believe it should be, is to survive. Service and education must rely on each other, lend each other their particular strengths and accept each other's judgment in their respective areas of expertise. This will lead to energy conservation for both and can result in both providing support to the staff nurse who carries the greatest responsibility for care.



M. Therese Schnurr, B.Sc.N. (U. of Seattle)M.N.(U. of Washington)

Present Position:
Director of Nursing Services, Registered Nurses' Association of British Columbia, Vancouver.

Association Activities:
CNA— member of ad hoc steering committee on development of a definition of nursing practice and development of standards for nursing practice (1975); member of resolutions committee (1970).

I accept the nomination as member-at-large for nursing practice. I am concerned about nursing practice in all areas of the health system and in this position it will be possible to work together towards the achievement of the essential goal, namely, the determination of the practice of nursing for the provision of quality care to Canadians. A concerted effort at the national level is essential to meet the challenge effectively.



Vera Louise Spencer, B.N. (McGill), M.P.H. (U. of Michigan)

Present Position:
Public Health Nursing Consultant, Department of Health, Regina, Sask.

Association Activities:
SRNA — committee on legislation and bylaws (1975-76), president at chapter and provincial levels (1965 - 67); CNA — member of board of directors (1965 - 67); CPHA — national and provincial executive member (1974 - 75); Canadian Cancer Society — member of board of directors, Saskatchewan division (1967 - 69).

My acceptance of the nomination as a member-at-large representing nursing services gave me the opportunity to re-examine my concerns and beliefs in nursing.

I believe the Canadian Nurses' Association has provided and should continue to provide leadership and to be concerned with the maintenance and improvement of health care services for all Canadians.

In pursuit of excellence, I believe it is the responsibility of each nurse, as a professional person, to maintain competency in whatever area of nursing they practice. I support and will encourage, not only the development of Canadian standards for nursing practice, but also accreditation of services in all fields of nursing so that efficient, effective, quality nursing care will be provided.

Nurses have a responsibility to challenge the present health care system and to assume leadership in the development of the philosophy of health promotion, and to promote and practice healthful living.

In a world which can be encompassed in ninety minutes it is necessary for nursing to continue to ensure the future advancement of health care services in all the communities of the world. The involvement of the Association in the helping role at the international level in my opinion, is essential if a successful worldwide nursing profession is to become a reality.

When looking to the future, plans must be based on the knowledge and understanding of both the past and present. The leadership role of the Association in the past has been demonstrated and the Association must continue to assume leadership and initiate future changes in nursing.

I would consider it a privilege to become involved in the concerns and responsibilities of Canadian nurses.

Candidates: Member-at-large, social and economic welfare



Elinor Margaret Bentley, RN (Royal Victoria Hospital), P.H.N. diploma (Dalhousie U.)

Present Position:
Consultant, Personnel Services, Registered Nurses' Association of Nova Scotia, Halifax.

Association Activities:
Consultant to and secretary of the provincial committee on social and economic welfare; secretary of N.S. Health Services and Insurance Commission/RNANS liaison committee; member ex-officio of various RNANS ad hoc committees; formerly member of board of directors (6 yrs) and past president (1972 - 73) of Public Health Association of Nova Scotia; member of Halifax Board of Trade Industrial Relations Committee; member of executive committee of Citizens' Advisory Board, Unemployment Insurance Commission.

Through education, liaison with resource persons and through briefs presented on their behalf, nurses have made great strides toward becoming a unified, decisive, recognized group of professional people. There is still a lot of work to do. It is my hope that I can offer stimulus and leadership to nurses to encourage them to become more involved in those matters of concern to themselves and to Canadians in general.



Linda Roberta Gosselin, RN (Toronto Western Hospital), B.Sc.N. (U. of Toronto).

Present Position:
Employment Relations Officer, Ontario Nurses' Association, Head Office, Toronto.

Association Activities:
RNAO — past member and now chairman of provincial committee on social and economic welfare, member of executive committee and board of directors (1974-76); formerly president, chairman, secretary and nurse representative of negotiating committee for the Nurses' Association of the Lakehead Regional School of Nursing.

I accepted the nomination for member-at-large, social and economic welfare, on the CNA Board of Directors because of my firm belief that nurses have the responsibility of being involved in the determination of their social and economic welfare.

The area of social and economic welfare is much broader than the examination of salaries and fringe benefits. It encompasses as well such issues as: hazards in the work environment, non-monetary working conditions which affect the quality and quantity of the care we provide for our clients and the satisfaction we derive from the provision of this care, the availability of ongoing educational programs to enable the nurse to maintain competency, the availability of programs to assist the nurse whose personal problems threaten the ability to practice.

As a profession, we must monitor and mold the influences on our social and economic welfare so that the practice of nursing will continue to be an attractive area of endeavor, so that the practitioners of nursing will enjoy security in the employment of their skills, and so that those nurses who have been engaged in laying the foundations for today's nurses can look forward to retiring in comfort.



Marie-Anne Toupin, B.N.(McGill), M.S.(U. of Colorado)

Present Position:
Administrative Assistant — Director of Nursing, Burnaby General Hospital, Burnaby, B.C.

Association Activities:
AARN — governing board(1974); member of ad hoc committee to assess genetic counseling needs for Alberta (1974); council representative, associate members United Nurses of Montreal (1967 - 69); ANPQ — chairman of public relations committee for Chapter XI, English chapter (1968 - 69); RNABC — member of task committee to review position paper on roles and function of registered nurses.

In this time of economic turmoil, nursing must maintain the gains it has achieved in economic and working conditions in the last few years. While working toward this, nurses and the profession must continue in the task of defining their functions as a member of the health care team. The community can only receive a high level of care if the profession continues to emphasize the necessity of adequate conditions of work and an environment conducive to efficiency and individual satisfaction.
I believe that the directions and goals for the profession in relation to social and economic welfare should be set at a national level to enable all nurses within the nation to benefit.

For these reasons, I am pleased to accept the nomination for member-at-large for social and economic welfare.

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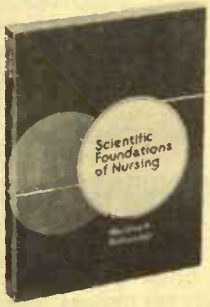
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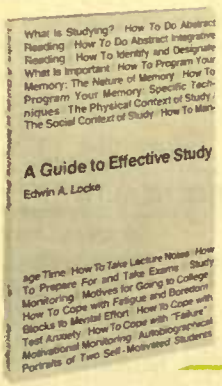
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Canadian Nurses' Association
Annual Meeting and Biennial Convention
Program Highlights



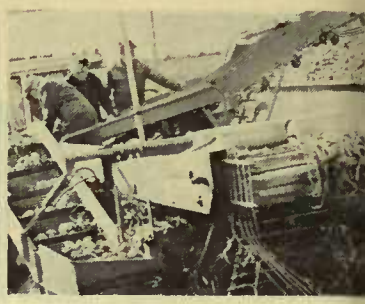



20

Sunday, June 20	
12:00 hours	Registration
14:00 hours	Canadian Nurses' Foundation — Annual Meeting
19:45 hours	Invocation — *Sister Barbara Muldoon*
20:00 hours	Opening Ceremony — Chairman — *Huguette Labelle* President CNA Minister of Health of Nova Scotia Mayor of Halifax — *Edmund Morris* Mayor of Dartmouth — *Irene Stubbs* Executive Director CNA Representatives — ICN, PAHO/WHO, ANA Welcome — Registered Nurses' Association of Nova Scotia
21:00 hours	Guest Speaker — **W.O. Mitchell**
22:00 hours	Reception — RNANS Welcome to Nova Scotia Punch Party

Place: Hotel Nova Scotian
Date: June 20-23, 1976
Theme: The Quality of Life



21

Monday, June 21

08:00 hours	Registration
08:30 hours	Report of the Committee on Nominations Nominations from the floor (delegates)
08:45 hours	Report of the Arrangements Committee — RNANS
09:00 hours	Keynote Speaker — **Ralph Nader** Following the address there will be an open forum discussion with the speaker.
14:00 hours	Debate "Resolved that nurses have a responsibility to take a stand to preserve life in the event of any decision by a patient, a family, or a professional to discontinue life-maintaining intervention." Chairman: Apolline Robichaud Participants: At press time confirmation had not yet been received regarding participants
15:30 hours	Interview by **Patrick Watson** Subject: The impact of the nursing profession on the quality of life. Interviewees: *Cathlyn Macaulay,* Head Nurse, Palliative Care Unit, Royal Victoria Hospital, Montreal. *Pamela Poole,* Chief, Information and Evaluation Division, Research Program Directorate, Federal Government. *Shirley Post,* Health Care Consultant. *Irene Desjarlais,* Nurse-in-charge, Medical Services Health Centre, Fort Qu'Appelle *Evening Recreation: Tour of Peggy's Cove or Water Tour of Halifax Harbour or Lobster Dinner and Ceilidh*

22

Tuesday, June 22

08:00 hours	Registration
09:00 hours	Opening Address Address, Huguette Labelle, President CNA Roll Call Reports: Executive Director Special Committees: Testing Service Treasurer's report Nursing Research Auditor's report Appointment of Auditor Mortgage burning ceremony Official admission of the NWTRNA *Evening Recreation: Tour of Peggy's Cove or Water Tour of Halifax Harbour or Lobster Dinner and Ceilidh*

Photos: Nova Scotia Communications & Information Centre






23

Wednesday, June 23

08:00 hours	Registration
09:00 hours	First Session: The quality of life in the work world of the nurse Chairman: *Jeannine Tellier-Cormier,* President of the Order of Nurses of Quebec Specific Topics: a) The incompatibility between educational preparation and the practice setting — *Ginette Rodger* — Director of Nursing, Notre Dame Hospital, Montreal b) not yet confirmed c) The enforced proximity to stressors in the client environment — *Mary Vachon* — Mental Health Consultant, Clarke Institute of Psychiatry, Toronto. d) The social and economic pressures in the work environment of the nurse — *Anne Gribben* — Chief Executive Officer of the Ontario Nurses' Association
11:00 hours	Second Session: You and the quality of life — action for today This session will feature an artistic representation of the theme.
14:00 hours	Report of the Resolutions Committee Report of the scrutineers
16:30 hours	Installation of Officers
19:30 hours	President's Reception

All events held in the Hotel Nova Scotian Commonwealth Room unless otherwise indicated

Coffee served daily from 10:30 hours to 11:00 hours Lunch Recess at 12:00 hours daily

Exhibits open at 09:00 hours daily from Monday, June 21 to Wednesday, June 23 at 13:00 hours

Canadian Nurses' Association
Balance sheet
December 31, 1975

Assets

	1975	1974
Current assets		
Cash in bank	$ 148,119	$ 97,132
Short term deposits plus accrued interest	536,357	712,593
Accounts receivable	58,824	51,280
Membership fees receivable	12,220	10,852
Prepaid expenses	11,519	10,292
	767,039	882,149
Sundry assets		
Marketable securities — at cost (quoted value $12,868; 1974 $9,957)	4,065	3,779
Loans to member nurses plus accrued interest	11,289	9,088
	15,354	12,867
Fixed assets — *note 1*		
C.N.A. House — land and building — at cost less accumulated depreciation on building	488,066	519,932
Furniture and fixtures — at nominal value	1	1
	488,067	519,933
	$1,270,460	$1,414,949

Liabilities and surplus

Current liabilities		
Accounts payable and accrued liabilities	$ 39,146	$ 20,863
Deferred revenue — subscriptions	21,900	27,500
— other	306	—
Mortgage payable within one year	324,534	20,235
	385,886	68,598
Mortgage payable — 6 3/4% due 1976 — payable in monthly instalments of $3,548 to include principal and interest (less portion payable within one year)	—	324,534
Grants for special projects — unexpended portion — *note 2*	31,493	—
Reserve for support to the Northwest Territories Registered Nurses Association — *note 3*	11,000	15,000
Surplus	842,081	1,006,817
	$1,270,460	**$1,414,949**

Approved on behalf of the Board:

Mme Huguette Labelle, *President*

Dr. Helen K. Mussallem, *Executive Director*

Canadian Nurses' Association
Testing service
Statement of income
Year ended December 31, 1975

	1975	1974
Revenue		
Examination fees	$ 401,534	303,703
Interest earned	4,153	5,691
	405,687	309,394
Expenditures:		
Salaries and benefits	176,493	142,656
Board and committee meetings	39,878	37,834
Item writing	23,457	19,123
Operating (data processing, printing, warehousing)	77,740	70,326
Consultants	5,239	—
Rent	28,570	7,869
Translation	5,478	705
Office supplies and stationery	8,726	4,765
Postage and express	3,612	2,472
Telephone and telegraph	4,046	2,737
Travel — non-committee	2,496	1,628
Equipment, maintenance and rental	884	866
Books and periodicals	562	467
Furniture and fixtures	10,417	7,700
Miscellaneous	3,737	994
Leasehold improvements	22,338	—
Moving expenses	787	—
Insurance	483	559
	414,943	300,701
Surplus (Deficit) for year	**$ (9,256)**	**$ 8,693**

Ve have examined the balance sheet of Canadian Nurses' Association
is at December 31, 1975 and the statements of income and surplus for
ne year then ended. Our examination included a general review of the
ccounting procedures and such tests of accounting records and other
upporting evidence as we considered necessary in the circumstances.

n our opinion these financial statements present fairly the financial
osition of the Association as at December 31, 1975 and the results of
s operations for the year then ended, in accordance with generally
ccepted accounting principles applied on a basis consistent with that
f the preceding year.

Geo. A. Welch & Company,
Chartered Accountants.

January 29, 1976

Canadian Nurses' Association
Notes to financial statements
December 31, 1975

1. Fixed assets
It is the policy of the Association to expense purchases of furniture and fixtures in the year of purchase. The C.N.A. House is being depreciated over 20 years at the rate of 5% per annum.

2. Grants for special projects
During the year Health and Welfare Canada and the Canadian International Development Agency advanced funds to the Association in respect of grants for special projects. The unexpended portion of these grants at December 31, 1975 totalled $31,493.

3. Special reserve
In 1974 a special reserve of $15,000 was established for support to the Northwest Territories Registered Nurses Association. In 1975 a payment of $4,000 was made to the Association leaving a balance of $11,000 at December 31, 1975.

4. Retirement income plan
During the year changes were made to the Association's retirement plan resulting in additional benefits for past service. Actuaries have estimated that an annual amount of $38,500 for 15 years will be required to fund the past service benefits.

Canadian Nurses' Association
Statement of income and surplus
Year ended December 31, 1975

	1975	1974
Revenue		
Membership fees	$ 955,238	$ 888,904
Subscriptions	38,922	40,820
Advertising	339,604	299,264
Sundry income	7,196	8,127
	1,340,960	1,237,115
Expenditures		
Operating expenses		
Salaries	759,924	568,306
Printing and publications	245,436	222,422
Design and graphics	14,399	7,943
Postage on journal	118,773	113,175
Computer service	44,894	25,658
Committee travel	36,272	23,176
Translation services	—	2,319
Commission on advertising sales	33,546	20,663
Affiliation fees — I.C.N.	65,707	47,130
— Canadian Council on Hospital Accreditation	5,000	5,000
Professional services	14,121	9,725
Travel — non-committee	22,347	12,061
Office expenses	36,614	35,387
Books and periodicals	10,238	6,645
Legal and audit	5,200	8,747
Building services	88,398	70,256
Sundry	13,725	5,320
Furniture and fixtures	2,954	602
Landscaping and improvements	189	948
Depreciation — C.N.A. House	31,867	31,867
Insurance	6,295	367
General meeting	1,661	—
Contingency for special projects	303	—
	1,557,863	1,217,717
Non-operating expenses:		
1974 convention	—	18,869
Canadian Nurses' Foundation — administration	—	1,954
	—	20,823
	1,557,863	1,238,540
Surplus (Deficit) for year before items below	(216,903)	(1,425)
C.N.A. Testing Service — per statement	(9,256)	8,693
Investment income	61,423	66,475
Surplus (Deficit) for year	(164,736)	73,743
Surplus at beginning of year	1,006,817	948,074
	842,081	1,021,817
Less reserve for Northwest Territories Registered Nurses Association	—	15,000
Surplus at end of year	**$ 842,081**	**$ 1,006,817**

Resolutions of the Board of Directors to the 1976 Annual Meeting and Convention

A. Changes in By-law

1. BE IT ENACTED as a By-law of Canadian Nurses' Association — Association des infirmières canadiennes (herein called "Association") that:

a) The Association be and is hereby authorized to make application to the Minister of Consumer and Corporate Affairs for supplementary letters patent amending the letters patent incorporating the Association by changing the name from "Canadian Nurses' Association — Association des infirmières canadiennes" to "Canadian Nurses Association — Association des infirmières et infirmiers du Canada" and amending paragraph D from:
"The membership of the Corporation shall consist of the ten (10) provincial associations: The Alberta Association of Registered Nurses, Registered Nurses' Association of British Columbia, The Manitoba Association of Registered Nurses, Association of Registered Nurses of Newfoundland, The Registered Nurses' Association of Nova Scotia, The New Brunswick Association of Registered Nurses, Registered Nurses' Association of Ontario, the Association of Nurses of the Province of Quebec, The Association of Nurses of Prince Edward Island, and the Saskatchewan Registered Nurses' Association, or their respective successors and assigns, and such other classes of members as the Corporation may establish by by-law from time to time."
to: "The membership of the Corporation shall consist of eleven (11) association members: Registered Nurses Association of British Columbia, Alberta Association of Registered Nurses, Saskatchewan Registered Nurses Association, Manitoba Association of Registered Nurses, Registered Nurses' Association of Ontario, Order of Nurses of Québec, The New Brunswick Association of Registered Nurses, Registered Nurses' Association of Nova Scotia, The Association of Nurses of Prince Edward Island, Association of Registered Nurses of Newfoundland, and Northwest Territories Registered Nurses' Association, or their respective successors and assigns, and such other classes of members as the Corporation may establish by by-law from time to time."

b) The directors and officers be and are hereby authorized and directed to do, sign and execute all things, deeds and documents necessary or desirable for the due carrying out of the foregoing, including effecting necessary editorial changes in the Association by-law.

2. Section 8(b)
five members-at-large, elected to represent respectively the fields of nursing administration, nursing education, nursing practice, nursing research, and social and economic welfare
(originally submitted by MARN)

3. Section 16
Powers and Functions: It shall be the responsibility of the board and the board shall have the authority (a) to establish the policy of the Association; (b) to revise the policy in the light of changing beliefs; (c) to appoint the executive director and delegate responsibility and authority for implementation of Association policies to this position; (d) to ensure that Association policies are implemented satisfactorily; (e) to report fully to the Association at each annual meeting upon the business transacted since the last annual meeting; (f) to honour those who have made an outstanding contribution to nursing; (g) to make decisions and to take all such appropriate action as is necessary to further the objects of the Association.

4. Section 25
Composition: There shall be a committee of nominations of three members elected at an annual meeting of the Association; one of whom shall be named chairman by the board.

5. Section 47(a)
A special committee may be established by the board at any time for a short or long term and may be dissolved by resolution of the board of directors. The appointment by the board shall set forth in reasonable detail the subject matter for study by the committee, its composition and such other terms as the board deems fit. (b) an ad hoc committee may be established by the board for a specific purpose on precise terms of reference which shall provide that the committee shall cease to function upon completion of the specific task; the composition and other terms of reference of the committee shall be set forth in the board's appointment. (c) there shall be a standing committee, known as the Testing Service Committee, constituted by the board of directors.

B. Others

1. THAT members of CNA be urged to initiate and conduct projects that will advance the discipline of nursing. (originally submitted by MARN)
2. THAT all CNA members be urged to support the CNF so that it can carry out its mandate, namely,

(a) to provide bursaries, scholarships and fellowships to persons enrolled in educational institutions for the purpose of obtaining a baccalaureate degree in nursing and to nurses enrolling in master's or doctoral degree programs;

(b) to provide grants in aid of or to undertake research in nursing science which may help to advance the knowledge and art of members of the nursing profession with a view to providing the best possible nursing care and attention;

(c) to solicit, acquire, accept or receive gifts, donations, bequests or subscriptions of money, or other real or personal property, whether they be unconditional or subject to special conditions, provided any special conditions are not inconsistent with the above objects.
(originally submitted by MARN)

3. THAT the CNA pursue with legal counsel the feasibility of trying to bring tobacco under the Food and Drug Act.
(originally submitted by MARN)
4. Whereas nurses are concerned about the quality of life; and Whereas nurses attempt to enhance the quality of life by their actions; therefore be it resolved:
THAT CNA take action to have removed from the market such items that are detrimental to health; and further be it resolved THAT nurses bring such items to the attention of CNA for action.
(originally submitted by RNAO)
5. The RNAO supports CNA in its efforts to provide statistical data

Resolutions

related to registered nurses in Canada and recommends that every effort be made to:

(a) maintain tables in a consistent manner so that their usefulness is maximized and trends can be monitored over time:

(b) ensure a publication date that allows data to be available when it is still relevant to planning for the profession;

(c) engage in a review of CNA's publication "Countdown" with a view to publishing current statistical information in that original format.

(originally submitted by RNAO)

6. Whereas it is unlikely that educational programs established by each province to prepare nurse-midwives would be viable, RNAO recommends that CNA, in conjunction with provincial nurses' associations, develop a position statement regarding a realistic distribution of educational programs for nurse-midwives in Canada.
(originally submitted by RNAO)
7. Whereas the Board of Directors has already allocated resources to the development of nursing practice standards in response to a resolution passed at the 1974 annual meeting and convention and, in view of the increasing need for national guidelines; be it resolved THAT the necessary resources continue to be allocated to ensure that the project on national standards for nursing practice be completed; and be it further resolved THAT this project be a priority in this biennium.
8. Whereas nurses are in a unique clinical role to maximize effectiveness and minimize side effects of pharmacotherapy; be it resolved THAT CNA seek funds to hold one or more symposia on the subject of pharmacotherapy to raise the level of awareness of nurses to their responsibility in this aspect of practice.
9. Whereas the Board of Directors has already allocated resources to the development of nursing education standards in response to a resolution passed at the 1974 annual meeting and convention, and in view of the increasing need for national guidelines; be it resolved THAT the necessary resources continue to be allocated to ensure that the project on national standards for nursing education be completed; and be it further resolved THAT this project be a priority in this biennium.
10. Whereas the CNA Health Promotion Program for Nurses was mounted in response to a resolution passed in 1974; and Whereas member associations have unanimously supported the Program; be it resolved THAT CNA seek funds to conduct a program in multi-risk health counselling for nurses in this biennium.
11. THAT CNA develop a policy statement on Consumers' Rights in Health Care, using the Consumers' Association of Canada document *Consumer Rights in Health Care* as a beginning point for discussion.

OFFICIAL NOTICE

Annual and Special General Meeting of the Canadian Nurses' Foundation

In accordance with By-law Section 36, notice is given of an annual and special general meeting to be held Sunday, 20 June 1976, commencing 1400 hours at the Nova Scotian Hotel, Halifax, Nova Scotia. The purpose of the meeting is to receive and consider the income and expenditure account, balance sheet, and annual reports. The election of the CNF Board of Directors for the 1976-78 term of office will be conducted during the meeting.

Members will be asked to consider a by-law of the Board of Directors concerning acceptance of a bilingual name for the Foundation and a related change in By-law Section 1.

All members of the Canadian Nurses' Foundation are eligible to attend and participate in the annual and special general meeting. — Helen K. Mussallem, Secretary-Treasurer, Canadian Nurses' Foundation.



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A conversation with the executive director



Q. How urgent is this need for an increase in fees?
A. Well, it's very urgent because CNA's cash reserves will be used up by the end of the year. Facing an operating deficit of approximately $424,000 this year, and continuing inflationary pressures in subsequent years, CNA will be unable to provide present services to the individual nurse member without additional financing.
Q. What services does the individual nurse get from CNA and how do these reach her?
A. CNA provides both tangible and intangible services to its members. The most visible product is the journal, sent monthly to each member in the language of choice. The journal continuously keeps members up-to-date with events and conditions that affect the nursing profession in Canada; with new nursing techniques; with the availability of new nursing literature — both in CNA library and from publishers — with employment opportunities, practical ideas, and so forth.
Of course, there are also the library services. Do you know, for instance, that ours is the only nationally recognized nursing library in Canada? Any CNA member can use the services through interlibrary loan, direct mail or at CNA House.
CNA also collects national statistics concerning nurses — where they work, what they do, what their level of education is. This is important, you know, because statistics are used to predict trends, for example, mobility, nursing manpower availability, distribution in institutions and salaries.
The intangibles are harder to assess but they affect the nurse in a deeper way. For instance, CNA speaks in a strong voice for the nursing profession nationally.
Q. What does this do for the individual nurse?
A. The individual nurse isn't always aware that her present professional role is a reality because the nurses that preceded her stood firm in promoting nursing as a profession. This was accomplished by nurses speaking out in a strong, united voice. An individual or a small group of individuals can speak out but, in order to be heard, you must have a strong organization representing a large percentage of the people concerned.
But CNA does more than this. To enhance and strengthen the nursing profession, CNA's professional advancement activities include such ongoing projects as the development of national standards for nursing education, nursing practice, the national survey on the nurse in the expanded role, and the national health promotion project. Of course, these are backed by research, library and office services. There is also the Nursing Abroad Program for Canadian nurses seeking employment or making professional visits abroad, the Extension Course in Nursing Unit Administration, the promotion of the Canadian Nurses' Foundation — oh, I could go on and on . . .
Q. To get back to the money question then, how can CNA's financial situation affect its services?
A. In a word, drastically. As I said before, CNA faces approximately a $424,000 deficit to carry on its programs this year. With rising costs, the situation will worsen, unless revenue is increased sufficiently.
Q. Where does CNA's revenue come from?
A. Most of it comes from membership fees. At present, CNA receives about $8.54 per member, or about 71 cents per month.
Q. When was the present fee established?
A. In 1966. There has been no increase in the past 10 years, and, as you know, the cost of everything has risen rapidly since then. I believe we are the only large association in Canada that has not had an increase in the last 10 years.
Q. Isn't the Board going to recommend a fee increase in June?
A. Yes, Board members have decided to recommend a $12.00 unit base for 1977 and a $15.00 unit base for 1978. Under the present fee formula, these units would produce average annual fees per member of about $10.00 in 1977 and $12.50 in 1978. Even this will not support the present level of programs.
Q. Is there any possibility that CNA might fold?
A. Oh, I would hope not. Of course, anything might fold. But I believe that any thinking nurse would look very carefully at what it would mean not to have a national nurses' association.
Q. How would this affect the individual Canadian nurse?
A. The best way to answer that question, perhaps, is to look at countries where there is no professional nurses' association or if there is one, it is very weak — and there are many countries in the world where this situation exists.
Q. How does this affect nurses?
A. Quite simply, nurses are unable to exert the necessary influence on the practice of nursing nor control the nursing profession. Someone else does.

Directors of CNA, when they met in February, decided to ask membership at the Association's annual meeting in June 1976 to approve an increase in fees. Realizing that this request would raise questions, *The Canadian Nurse* asked Helen Mussallem, Executive Director of CNA, for an assessment of our financial situation and an explanation of the need for an increase. Here, in question and answer form, is an excerpt from that interview.

If there was no national nurses' association in Canada, there would be no opportunity to implement programs and projects that would enhance the practice of nursing and promote better health care. Without a national association, there would be no organization at the national level that could speak on behalf of the nursing profession. When the need for nursing input at the federal or international level arose, other professions would be asked to give information on nursing and the role of the nurse. I ask the individual nurse . . . Do you want another group in the health profession speaking for you?

Q. How important is CNA to the individual nurse?

A. It is difficult to predict the future but it is certainly measurable in terms of importance in the past. Let's take a few examples: First, in the late 50's and early 60's, nursing salaries and working conditions were lagging behind. The CNA provided leadership, guides, assistance and statistical data in establishing the processes of collective bargaining. Ultimately, this program became provincially-centered and, as a result, nurses' salaries and working conditions improved.

In the 60's, also, nursing education became an increasingly controversial subject. Because CNA was financially solvent and energetic, it was able to launch a national pilot project to evaluate the diploma schools of nursing. There is well-documented evidence that this study spearheaded the drive to move diploma schools into the educational systems of the country. This is still going on.

A third example: A few years ago, there was a movement — rather strongly-based — to introduce into the health field a "physician's assistant," based on the U.S. model. CNA took a firm stand against the introduction of this new worker into the health field and was successful. We have been assured now that this action was to the public's advantage — and the Association has been commended for its leadership.

Q. Could CNA exist without doing these things? In other words, could CNA become just a small secretariat?

A. Well, that's a different question. If CNA became a small secretariat, there would indeed still be a national association but services would depend on the extent of available financial and human resources. Canadian nurses have struggled long and hard for the right to manage their own profession and I do not think they would want to abandon their present position.

Q. But if it did become a small secretariat, what would have to be sacrificed?

A. That's a difficult one. If CNA became a small secretariat, operating at a very minimal level, it would mean that there would be no journals, nor other current services — little more than what is required in the Letters Patent and By-law, holding an annual meeting and electing a Board of Directors. No journals, no library, no projects — nothing except limited communications.

Q. And the Testing Service, what would its future be?

A. Well, the Testing Service is self-supporting.

Q. Let's take another tack. Do you think other professional associations are also doing some soul-searching about their validity and relevance?

A. Yes, judging from current literature and comments, and I believe that this is healthy. All associations should be subject to periodic examination. They should be ready to change direction; they should be capable of self-renewal; they should be flexible and still be able to satisfy the expectations of members and society.

Q. You stated earlier that one of CNA's greatest roles is communicating and speaking out on issues. Could you elaborate on this?

A. Right. This Association should speak out on issues of national concern related to health and nursing. It must take a stand on issues related to nurses, nursing, health and sometimes on social issues. The responsibility of speaking for the organized profession of nursing, particularly when it comes to taking public stands on issues, is extremely serious and has many implications. It must be done with excellence — with complete and adequate research, and with full awareness and consideration of the future implications of the stand taken. Only in this way will the profession gain respect and acceptance and earn the right to stand as equal with other recognized professions.

Q. In view of what we have just been talking about, it seems that, in June, the voting delegates will have a tremendous responsibility.

A. Oh, yes. An extremely important responsibility.

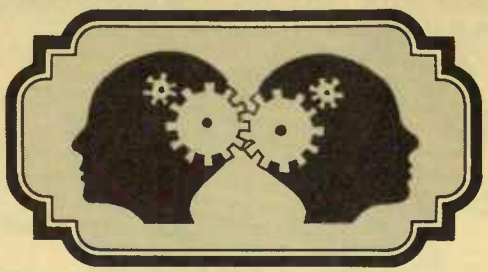
Q. Can we go so far as to say they are holding the future of CNA in their hands?

A. Yes. Every annual meeting does, but this one even more so.

Q. Are you hopeful that members will solve this problem at the annual meeting?

A. I most certainly am. CNA members have faced many problems since the Association was formed. They have always solved them. They will solve this one, too!

connection



Faith Warren

That Cup of Tea

I lay stretched out in a bed that was whiter than white, my nose in perfect alignment with the counterpane crease. All my working life, I'd either been at the top, sides, or bottom of the bed, and now I was *in* it! The wristband showed my name and hospital number. Metal railings on either side of me reminded me that I had to *stay* in bed.

But I wasn't at all comfortable. A nice cup of tea was what I wanted more than anything else in the world. Hot tea, in a china cup, with a little cream and sugar added. Maybe if I called someone, I'd get it.

I tugged at the string beside my bed, and, momentarily, a bright light blinded me. My body had left the bed. I was in orbit but my soul stayed behind on that hard hospital bed. Maybe this was what dying was all about?

Suddenly I realized my new dentures were left behind in a stainless steel cup on my locker. I pulled at the cord once more, and the bright light went off. So I was back in my bed again, but my thirst remained. Had I made it into Heaven, maybe I would now be drinking crystal clear water from an everlasting fountain. I tried the other cord.

A man in white stood at the side of my bed. He had long, golden hair with a beard to match, but no wings that I could see. "I'm thirsty," I said, "Couldn't I please have a cup of tea?" Sadly, he shook his head, and began to walk away. "Young man," I called,"surely, as a doctor you know I'm here to be cared for." He now looked even sadder. "Lady" he said, "I'm no doctor, I'm the maintenance man checking the plugs."

Well, better luck next time. A girl in pink came in and began wiping the top of my locker. "Would you raise my bed so as I can have a drink?" I asked. "Sorry, I'm not allowed to touch your bed. I'm in the building services department, and we have our union rules." But she wasn't building, she was cleaning... "Then you must be a sort of housekeeper," I ventured. She put her hands on her hips and glared at me. "Indeed," she said, "I have my duties, but we aren't called housekeepers any more."

So I tried the bell again, and a figure in a blue pantsuit came through the door. "Are you a nurse?" I asked hopefully. "Yes, I'm a grad." she answered. This was confusing. I expected every nurse to wear a cap and white uniform. "Times change!" she said and proceeded to lower one of my bed rails to sit on my bed.

Before I could ask for a cup of tea, a backrub, my dentures in, or my hair combed, she had launched into the story of her life. She had worked shifts to put her husband through medical school. Now he had his degree, and she wanted to be a doctor, but he wanted her to be the mother of his child. "Does he think I'm just a baby machine?" she asked. She wiped her eyes with one of my tissues. "I'm a person!" she said, bouncing off my bed, and leaving me more thirsty than ever.

Now that the railing was down, I could get out of bed and find the kitchen. But no sooner had my feet touched the floor than several figures rushed at me. I was hustled back into bed, and the railing imprisoned me again. With my tongue cleaving to the roof of my mouth, shouted weakly: "All I want is a cup of tea!"

What was the use? But I would try again maybe this time I would get some help. A face appeared. It said, "You are to have an intravenous, nothing by mouth, so please be quiet!" I demanded to see the head nurse. "She's at coffee," was the reply. She could have her coffee, and I couldn't have my tea.

A man in a clergyman's collar stood at the foot of my bed. "I'm the hospital chaplain and I'd like to pray for you." He opened his book and recited from it. His visit had given me hope.

Maybe God would send one of his angels to minister to me. Surely this wasn't too much to expect? Weren't sparrows counted and lilies of the field painted? How often had I comforted patients with the assurance that "God cares."

What was the advice our supervisor used to give to new patients? Going back through the years, I heard her voice.

"Keep your bed tidy,
Keep your bowels open,
Trust in the Lord,
And you will soon get home."

Or did she put "Trust in the Lord first?" Closing my eyes, I tried to remember.

I was a little girl again. With my best friend Mary Ellen, we had gone to a Gospel meeting in a tent in the big field near the bend in the river. We had clapped our hands and sung about "Living Water."

I opened my eyes and, surprisingly, felt much better,even without that cup of tea. My hand felt heavy, and I couldn't raise it. Had I had a stroke? Please God, NO! Someone touched my heavy hand. She wore a white uniform and a cap, and her shiny hospital pin winked at me. She said, "I'm back from coffee and have started an intravenous. This will make you much more comfortable." Then she smiled at me with such warmth that a wonderful feeling of relaxation flowed from my head to my toes.

I smiled back, and tried to get my nose in perfect alignment with the center fold of the counterpane. I was at peace with the world. The head nurse had had her coffee, and I wasn't nearly as thirsty. Soon I'd be able to go home and get that cup of tea. "Try to take a little nap," said the lady in white, touching my forehead. I closed my eyes and tried to think of myself as a sparrow sleeping in a bed of lily petals. God cares! I slept. ✤

Books

Understanding Psychiatric Nursing by David Towell, Royal College of Nursing, United Kingdom, 1975.
Reviewed by Anne Sauchuk, Teacher, Psychiatric Nursing, St. Clair College, Windsor, Ontario.

This book is based on sociologist Towell's PhD thesis in which he sought to examine what the psychiatric nurse's work involved, what understandings guided the work and what student nurses learn from their experience on the wards during their training.

During his four-year study (1967-1971) he mixed with staff at all levels; he was a participant observer with a new class of students both in the class and on the wards; he conducted periodic questionnaires and activity studies; used staff notes and informal interviews; and he attended nursing "handover meetings" and observed nurse-patient and staff interactions.

His study included a two-month observation period of the function of junior nurses in an admission and geriatric unit as well as in a therapeutic community which was being reorganized.

The age of the study, the domestic activities involved and the apprenticeship system of training British nurses prevent a direct translation of Towell's results to the Canadian situation. But the very human responses of the nurses caught in the pressure play between treatment ideologies, centralized administrative directives, nursing hierarchy, and the medical model of institutional structure are also Canadian problems. Shortage of staff, the lack of acceptance of people labelled as personality disorders, the dehumanization of geriatric patients and the frustration and search for role identification in the therapeutic community are prevalent in Canadian hospitals as well.

Towell's quotations of written reports and verbal interactions as well as his excerpts from observed interactions allows the reader a sympathetic, but objective view of the variety of functions, ideologies, attitudes, prejudices and pressures to conform of the psychiatric nurse.

The problems presented are not new but the book is based on good solid research and Towell's sociological analysis clarifies problem areas so that nurses have the opportunity of formulating their own solutions.

This book should be studied and discussed by all psychiatric nurses, teachers and administrators.

The Human Heart: A Guide to Heart Disease 3ed. by Brendan Phibbs. St. Louis, The C.V. Mosby Company 1975. 272 pages.
Reviewed by Candace Paris, Instructor, Niagara College of Applied Arts and Technology, The Mack Centre of Nursing Education, St. Catharines, Ontario.

The author has written this book for patients with heart disease. His belief that "to the heart patient, accurate knowledge often means life," promoted him to write a book in clear, easy-to-understand terms. This up-dated third edition achieves this goal.

The first six chapters make it possible for the "lay person" to understand the basic anatomy and physiology of the cardiovascular system. These chapters are succinct and amply illustrated with simple but accurate diagrams. All patients for whom this book is recommended must read and understand these chapters before continuing to learn about their particular cardiac problem.

All aspects of cardiac disease are then adequately outlined and illustrated in individual chapters. Some of these are Rheumatic Fever, Infectious Heart Disease, Hypertensive Heart Disease, Congenital Heart Malformations, Cardiac Arrhythmias, Pregnancy and Heart Disease, and Heart Surgery. An excellent chapter on "What To Do About a Heart Attack" is also included. It not only describes the manifestations, but clearly outlines the emergency "on-the-scene" treatment.

This book is a valuable reference for medical personnel to recommend to cardiac patients.

The price of the book, at $7.90, is not excessive. The print is large and easily read, and the complete index makes locating specific areas of interest a simple matter. Medical personnel ought to familiarize themselves with this book as it can be an important aid in planning health teaching for the cardiac patient by focusing on the important facts, and stating them in terms which the anxious patient can understand.

Library Update

Publications recently received in the Canadian Nurses' Association Library are available on *loan* — with the exception of items marked **R** — to CNA members, schools of nursing, and other institutions. Items marked **R** include reference and archive material that does *not* go out on loan. Theses, also **R**, are on Reserve and go out on Interlibrary Loan only.

Requests for loans, maximum 3 at a *time*, should be made on a standard Interlibrary Loan form or by letter giving author, title and item number in this list.

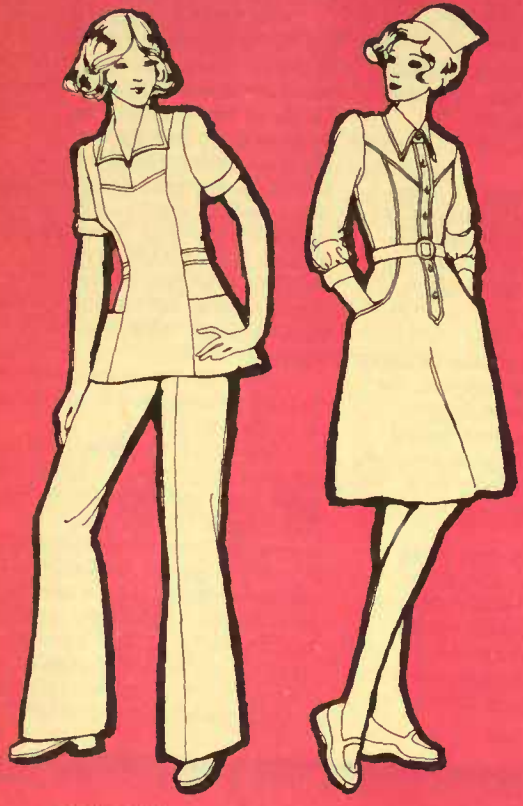
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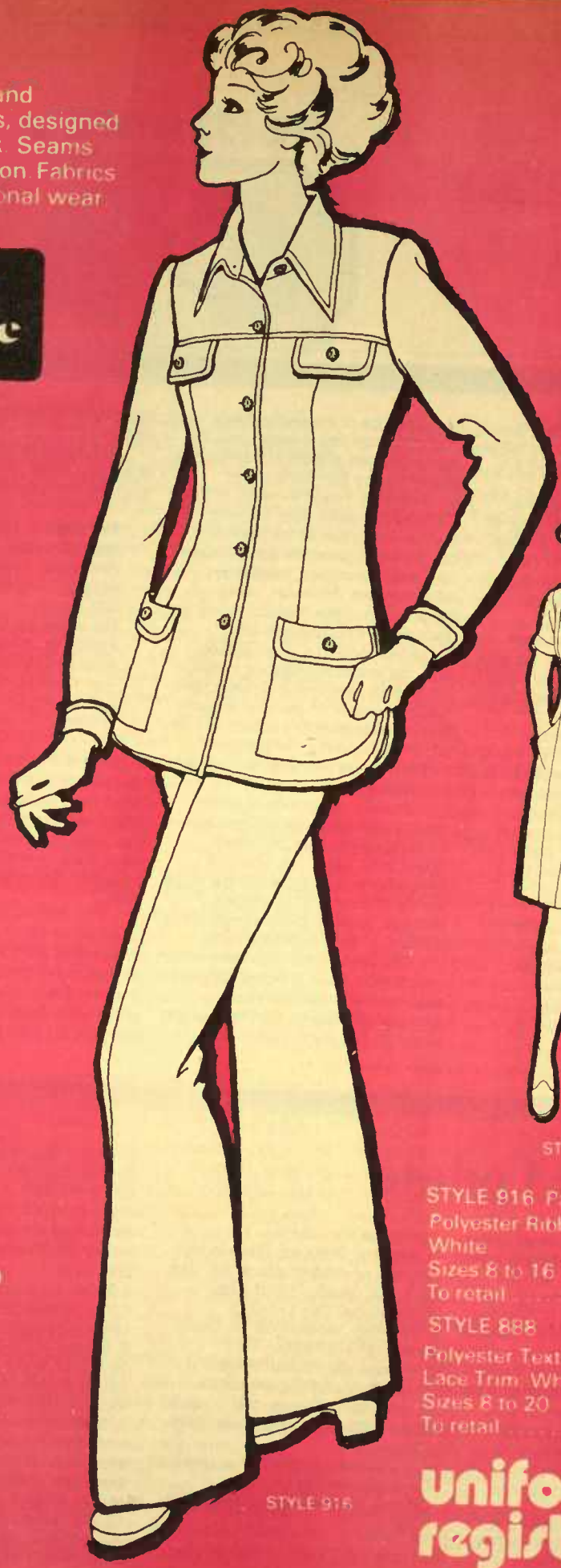
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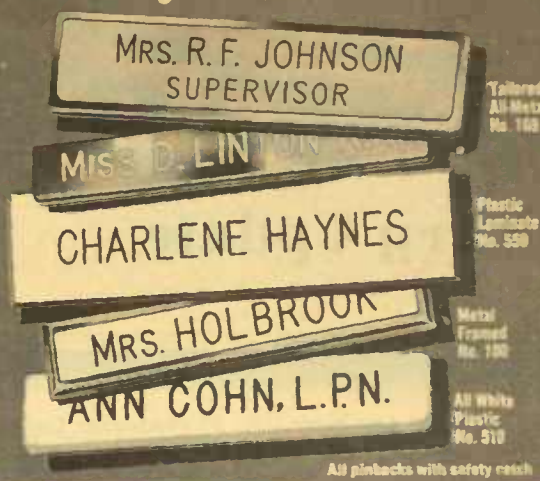
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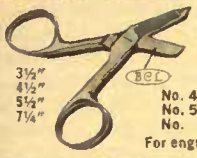
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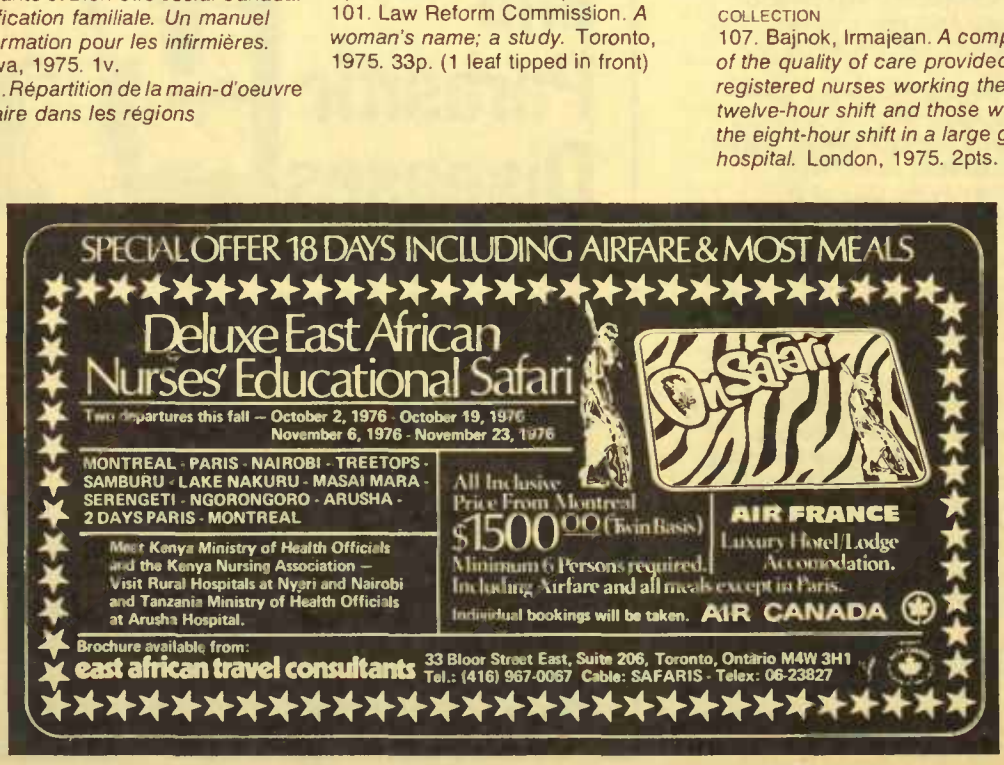
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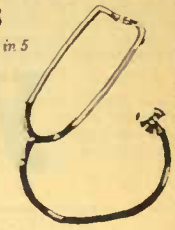


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And should submit:

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- Copies of the educational qualifications submitted on entry to nursing school;
- Verification of their R.N. Diploma, or equivalent;
- Their proposed course of study;
- Acceptances and/or preferences for place of study;
- Two character reference letters.

To: Philip G.C. Ketchum,
Chairman, The Board of Trustees,
Judy Hill Memorial Fund,
829 Centennial Building,
Edmonton, Alberta,
Canada.

By: May 1st, 1976

* The Scholarship is contingent on the successful applicant's being registrable by a nursing association in one of the Canadian provinces and meeting current Canadian immigration requirements for landed immigrant status. A successful applicant from outside Canada will be assisted by the Trustees in meeting these requirements.

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School of Nursing

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150 McTavish Avenue East
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R7A 2B3

The Registered Nurses' Association of Nova Scotia

invites applications for the position of

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The applicant should have a broad nursing background, administrative experience and university preparation, preferably at the Master's level. A background in professional association activities would be an asset.

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Interested qualified applicants should apply to:
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The official journal of the Canadian Nurses' Association published monthly in French and English editions.

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A dramatic moment in the life of a newborn baby is caught by a photographer from The Hospital for Sick Children in Toronto and featured on this month's *Canadian Nurse* cover. The nurse in the picture is Janice Gash, co-author of Transport of Neonates: a Matter of Prevention.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses' Association.

ISSN 0008-4581

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Canadian Nurses' Association, 50 The Driveway, Ottawa, Canada, K2P 1E2.

Perspective

They didn't look much like butterflies... especially in the heavy coats and high boots that go along with a late spring in Ottawa. Many of them were young; at least one had solved her baby-sitting problem by bringing the youngest member of the family along. Their faces reflected concern and, when they spoke, there was emotion in their voices. They looked like people who might get up while it is still dark to work an eight-hour shift or go off to work in the evening when everyone else is getting ready to call it a day. They looked like people who spend weekends as well as weekdays caring for other people.

That's why it was startling to hear one of the more than 700 nurses at a mass rally in the national capital warn her colleagues that they should beware of turning into "color-coded butterflies who have neither names nor titles." On second thought, however, the warning was both timely and appropriate. The meeting had been called to discuss cutbacks in spending in the health care field in Ontario and the effect of these measures on the nursing profession. The "butterfly warning" was based on the observation of one of the nurses present that, in at least one local hospital, there were indications of a trend towards the identification of different categories of health workers only by color-keyed badges designed to indicate their respective levels in the hospital hierarchy.

The speaker pointed out that if everyone responsible for patient care — nurses, nursing assistants, technicians, technologists, dietitians and therapists — dressed in look-alike pastel uniforms, with no visible symbols of their occupation, it would be difficult for a patient to decide just who to ask for what.

The problem goes deeper than the relatively insignificant issue of what the well-dressed nurse should wear to work, or even the attempt declare the traditional cap and pin obsolete. There seems to be a growing need for nurses to protect their professional identity in other ways as well— to recognize and reflect their unique contribution to the health care system.

As budgets become tighter it seems inevitable that the status nurses have worked so hard to achieve will be increasingly threatened by inadequate staffing patterns and that pressure will be exerted on RN's to delegate some of the responsibilities their experience and education have prepared them to accept. Already, there are hospitals in Ontario that have published lists of medications that may be administered by RNA's. The notion that RN's no longer have the time to provide the direct patient care involved in "bedside nursing" has become increasingly common among members of the general public. Is the role of the nurse to be further eroded by pragmatic solutions to budgetary problems?

It seems to me that unless nurses, through their professional associations and bargaining units make the hospital administration aware of their absolute rejection of this kind of solution to demands for reductions in health care costs, they are in danger of losing their professional identity and of contributing to lower standards of nursing care.

— M.A.H.

Herein

Next month, a nurse who has worked closely with many victims of breast cancer talks about the role of the health care worker in the detection and treatment of the number one killer of Canadian women in the 35 to 50 age group.

Author Ada Butler, an assistant professor at the school of nursing, University of British Columbia, says that the nurse who responds in a sensitive and relevant way can do a great deal to improve the length and quality of life of patients who are threatened by this disease. In next month's feature article, she gives some helpful advice on understandin the common problems faced by women with breast cancer.

A Toronto pediatrician claims "a goo incubator and a specially trained nurse can make all the difference between life and death or between healthy or defective individual later life." Dr. Graham Chance told the Clinical Research Society in that ci recently that a study of newborn



babies under four pounds admitted t the Hospital for Sick Children has shown conclusively that expert care i transporting these babies from one hospital to another can save lives, avert permanent injury and reduce time in hospital by half. Two nurse from the Hospital for Sick Children describe the planning and techniqu involved in this expert care on page of this issue of *The Canadian Nurs*

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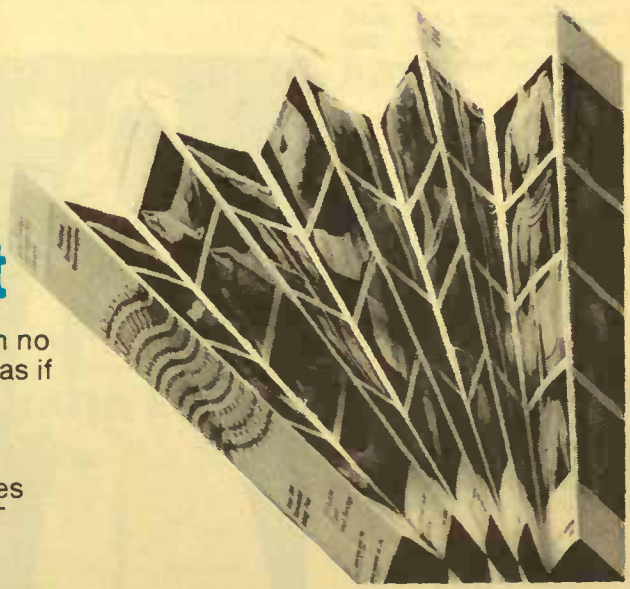


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The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

Input

The caring profession

I wish to comment on two articles in your journal of January, 1976. Joy Utema must be a wonderful nurse who doesn't have to hide behind a uniform to keep her self-respect, but can be simply a 'caring' human being by sharing her tears with a patient.

A nurse may not really learn how to give complete care to a dying patient until she has gone through a death of a loved one and/or analyzed her own feelings. After I nursed my terminally ill mother, I was more able to assist my patients who were dying or had lost a loved one.

May I also congratulate the authors, McGreevy and Van Heukelem for their excellent essay, "Crying: The Neglected Dimension." Their statements ring true from personal experience: some patients tend to recover after crying. And therapeutic crying, considered 'unprofessional,' is not usually in nursing school curriculae.

I couldn't agree more that the nurse must help the patient maintain self-esteem. Naturally, it is easier for the nurse to identify the unmet physical or emotional needs of the patient that result in crying. But how difficult for a nurse to identify a patient's unmet spiritual needs.

On the admitting sheet of our charts, there is a line to fill in: does the patient wish his minister to be notified? Once I was very happy to see how beneficial this visit was to an anxious teenager undergoing surgery the next day. Normally that surgical procedure is quite painful but her minister's talk and prayer did more for that patient in getting well *faster*, than a whole week of narcotic pills so easily handed out on order.

— Yvonne Birrell, R.D.H, R.N., Stayner, Ontario.

R.N.'s — Obsolete?

A pharmacy department in one of our local hospitals recently published a list of approved medications that Registered Nursing Assistants will be allowed to administer to patients.

I believe that this decision is a portent of things to come: Registered Nurses will become obsolete.

R.N.A.'s are often hired now in preference to R.N.'s, mainly because of budget, but, R.N.'s *had* a stronghold. Many procedures (one of which was giving medication) could only be performed by R.N.'s. Now with R.N.A.'s being able to give medications (no matter how insignificant they are and no medication IS insignificant), R.N.'s are losing their expertise or their "raison d'être."

Why should one bother to spend the time and money to become an R.N. when, with less time and money —one could become an R.N.A. and do the same thing? The situation is nearing that stage.

I do not intend, in any way, to degrade the work of R.N.A.'s — but, I believe that nurses (R.N.'s) need to stand up — they need to protect themselves. R.N.A.'s should protect themselves from lawsuits and refuse to take the responsibility of administering medications.

I hope that readers will express their concern about this issue to their provincial organizations — stand up and fight for nursing.

— L. Cranston, Ottawa, Ontario.

Unfair to Flo?

Concerning Pat Barr's letter ("Input," /March, 1976) I can only ask that she read *Florence Nightingale.* Cecil Woodham-Smith's book is, I feel, a fair view of the life and efforts of Flo. It was published first in 1951 and has been reprinted most recently in 1970 by Collins, Fontana Books.

After reading this account, I cannot help but disagree with some of the comments and interpretations that Ms. Barr makes of Ms. Nightingale.

— Lise Kear, Huntsville, Ontario.

A Pat on the Back

I feel I must congratulate you and your production department on the outstanding renovations. Bravo!

Would this be an inopportune time to suggest that a combined English/French edition of *The Canadian Nurse* would be of very great interest to us as advertisers? There are some precedents in the health area, as you know. In any case I do not want this thought in any way to detract from the original purpose of this letter which was to commend *The Canadian Nurse* for such an outstanding change.—

Charles W. Lindsay, President, J.B. Lippincott Company of Canada Ltd. Toronto.

Congratulations on an excellent issue of *The Canadian Nurse* (Feb. 1976). I find the new style and format very appealing.

Especially did I enjoy your editorial on assertiveness training for nurses. I am more and more convinced that few changes in nursing and nursing are more urgently needed.

Can we look forward to some dialogue on this concept in *The Canadian Nurse?*

Keep up the excellent work.

— Gloria Boerma, Reg. N., B.S.N., Saskatoon, Sask.

A case for life

Vincent Adamkiewicz (February 1976) presents factual and scientific evidence that the developing fetus is indeed living and human from the moment of conception.

How can we justify the number of lives lost due to the seemingly simple medical procedure called abortion?

— Bernice Ward, R.N., B.Sc.N., Edmonton, Alta.

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Input

Editor's note: The following open letter was submitted simultaneously to both the RNABC News and The Canadian Nurse. The author asks that it be published in this journal "since it is a topic which affects the membership [of the nursing profession] as a whole."

Handmaidens protest

Yes, nurses must be accountable, not only as individuals, but as the Canadian Nurses Association. As a member of the Association, I am ashamed that we haven't taken a stand on abortion.

I am not against abortion, providing it is done in the first 2 - 3 months, before there is an audible fetal heart. What I am against, are abortions at four months gestation by means of instilling a hypertonic saline solution into the woman's uterus. Charting consists of "fetal heart heard per doptone" — and then the procedure is charted — and we wait for that fetus to die and be aborted — hopefully it will be dead and not gasping for breath as it is expelled.

Is this nursing as we pledged to carry it out — being "handmaidens" to doctors that continue to do these "fetacide-abortions?" How can we justify this, when on the other end of the spectrum we hear a cardiac arrest call and we rush to breathe air into the lungs and massage the heart of a person that is dying? It doesn't make sense. In other words — are we being accountable?

What suggestions have I got for this horrendous problem in today's society?

First, we must through our Canadian Nurses Association bring pressure on the Canadian Medical Association to stop doing abortions when there is an audible fetal heart. I am sure there are many doctors that feel this practice is wrong and only require some stimulus to get them to stand up and be heard.

Next, let's stop using valuable hospital beds for abortions and establish properly run abortion clinics.

Thirdly, and I feel most important, let's press for well publicized, family planning and sex education clinics.

Now I know there are those among you that will say — this is all very good, but if a woman can't get an abortion "legally" (because there is a fetal heart) she will go to some back street abortionist often with sad results. It is this rationalization, that has made these late abortions seem acceptable.

It would be my hope that through improved contraception education and abortion facilities that these advanced abortions would be eliminated. As it now stands, I feel every time there is an abortion done on a woman with an audible fetal heart — the doctor and nurse who initiate the abortion are being used — used because society as a whole is no longer accountable. Let's try to alter this now, and we as nurses stand up in force through our Association, and say we will no longer perpetuate an intolerable situation. Stop being "handmaidens" and show that you do have an opinion. Let's be accountable! *— Marjorie P. Shier, North Vancouver, B.C.*

Professional challenge

It was with considerable interest and relief that I read the article by Dr. Adamkiewicz, "What Are the Bonds Between the Fetus and the Uterus?" There is currently a very blasé attitude amongst health professionals and educators concerning abortion — the opinion that it is not a criminal act to destroy the life of the unborn fetus, a life which has the full potential of a human being. Under the rather weak excuse of wanting "to help women in trouble," we as nurses are contradicting a basic, deep principle in in our philosophy of care, which is to preserve life.

As a concerned citizen and a teacher of future nurses, I agree with Dr. Adamkiewicz that we must bring our skills, high ideals and influence together to fight the current pro-abortion trend and provide the fetus with that community protection to which he is justly entitled . — *Carol Lawson, Pediatric Nursing Instructor, Vanier College, Ste-Croix Campus, Montreal.*

Demeaning viewpoint

I found Viewpoint (*The Canadian Nurse*, February 1976) inappropriate and objectionable for a professional journal. Dr. Adamkiewicz rambles in irrelevancies and reiteration of patently obvious factual data on a subject which he purports to understand.

The title "What Are the Bonds Between the Fetus and the Uterus?" clearly indicates evasion of the real issue in abortion debates. It is not the uterus which demands decision-making rights, but the woman who happens to possess that organ. Suggesting extraterritorial status for the pregnant uterus is the height of conceptualization without reason.

Publication of this demeaning and poorly "conceived" article coupled with an editorial challenge to nurses as health care providers seems unwarranted. Surely our editors could solicit a more objective and informed viewpoint.— *Bettie J. Scheffer, RN, Vancouver, B.C.*

Peripatetic profession

I wish to add some weight to the side of the nurses who are unhappy with different provincial registrations across Canada. *(The Canadian Nurse, January 1976).* I feel there are two things which make this situation difficult to work with.

The first is that people *are* in general more peripatetic. Not only nurses move about but also husbands and other family members. I find myself changing provinces to look after a Mom with lung cancer. This was not planned to suit registration times.

This brings me to my second consideration, which is financial. Since I have just paid $70.00 registration fees in Manitoba, $22.50 PHA fees, and $12.00 Associate fees to my home school (the AARN), my total registration fees this year will be over $200.00 if I pay $110.00 to the RNABC !!! Whew! *—B.E. Gunn, R.N., B.Sc. P.H.N., West Vancouver, B.C.*

Gypsy in our soul

I have always looked forward to *The Canadian Nurse* and have often received useful, practical, information from this journal. I am writing now to bring your attention to a problem that I share with a lot of nurses in our mobile society. I've just spent three hours completing forms, writing cheques and letters, and hunting for everythin from school marks to marriage certificates. It is an experience that we all must face each time we change ou province of residence and it doesn't make much sense.

Why, in a country where each province has identical registration requirements, don't we have a sing Canadian Registration? It would sav the "gypsies" among us, and our various provincial associations a grea deal of time, money and frustration.

I truly hope that a time will com when I am a "Canadian Nurse" and please let it be before I move again *Dona M. Penkala, Pasadena, Nfld.*

Prisoners of conscience

Thousands of men and women are being detained in Soviet prisons corrective labor colonies and psychiatric hospitals because of the religious or political beliefs. In contemporary Soviet law (penal) the "infliction of suffering" is regarded a permissible and necessary.

In more than 14 years of work o violations of human rights throughou the world, Amnesty International ha accumulated a great deal of information on the treatment and conditions of prisoners of conscienc in the USSR. This information is no available with the release in five languages of "Prisoners of Conscience in the USSR: Their treatment and conditions."

The documented evidence of maltreatment by Soviet physicians, psychiatrists, and paramedical personnel will be of particular intere to nurses. The report is available fro Amnesty International for $2.50. *— Mary J. Beattie, Amnesty International, 2101 Algonquin Avenue, Ottawa, Ont., K2A 1T2.*

New horizons

I am writing this letter to ask you favor. I am 26 years old and would lik to correspond with someone interested in nursing. So, please be kind enough to publish my address one of your nursing journals. *—(Miss) Ramya Nancyakkara, No. 121/3, Lady McCallum's Drive, Kandy. Sri Lanka. (Ceylon).*

(Continued on p. 1

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News

Belt-tightening hits nurses, national outlook bleak

When the federal government officially put the lid on health care costs by introducing Bill C-68, closely followed by announcement of a national anti-inflation program, most provinces reacted by initiating cutbacks and curtailments in their health services.

Under Bill C-68, the federal government would limit future increases in contributions to medicare to 13 percent in 1976-77 and 10.5 percent in 1977-78. At the same time, the government served notice of its intention to end existing agreements under the Hospital Insurance and Diagnostic Care Act, through which each province recovers about half of its hospital expenditures.

"Hold-the-line" budgets are fast becoming a fact of life in most provinces, with varying effects on the level of health services available and the personnel who provide them. Representatives of provincial nurses' associations were contacted recently by *The Canadian Nurse* in an attempt to obtain a national picture of the effect of these austerity measures on nursing manpower in their jurisdictions.

Although the situation varies from province to province, and from one area to another in the same province, as well as seasonally, the general impression provided by these spokesmen, was that of a general tightening up in employment prospects, with pockets of serious unemployment becoming apparent in several centres. Short-term prospects are not generally encouraging for the recent graduate or for nurses with a definite preference for working in a particular city or hospital.

Some of the comments follow:

British Columbia

Although jobs for registered nurses in British Columbia were in relatively short supply in late Winter, the situation was expected to improve by Spring, according to Registered Nurses Association of British Columbia Employment Referral Director, Marilyn Carmack.

"The number of nursing jobs listed with us drops every year at this time," she says. "Things are tighter than usual, but the situation should change — despite budget cutbacks at some hospitals." A similar situation existed in 1970 and rumors then of a lack of jobs created a critical shortage of nurses in British Columbia that lasted nearly five years.

The association's employment referral service listed nearly 100 job vacancies and about 65 new enrollees looking for work early in 1976. Comparable figures for 1975 show about 200 vacancies and 50 new enrollees. Many of the jobs go unfilled because they are outside the Lower Mainland, according to Carmack, and others may require nurses with hard-to-find clinical specialties. "The apparent lack of jobs should disappear," said Carmack. "Any other view of the situation is unrealistic." She notes that British Columbia trains only about 30 percent of its new registered nurses and must import the rest from other provinces and outside Canada.

Alberta

The registrar of the Alberta Association of Registered Nurses indicates that the supply of nurses appears "generally equal to the demand" although in certain sections of the province, some levels of unemployment are being experienced. A few vacancies still exist in northern areas.

As of February 2, 1976, all graduates seeking registration in Alberta whose credentials meet the requirements for registration must pass either the Canadian Nurses Association Testing Service or the National League of Nursing examinations in medical nursing, surgical nursing, obstetrical nursing, and the nursing of children. Graduates of 1972 or later must also pass the registration examination in psychiatric nursing.



Close to 750 Eastern Ontario nurses at a mass meeting in Ottawa heard Anne Gribben, chief executive officer of the Ontario Nurses' Association, warn that provincial health-care cutbacks threaten public safety as well as the jobs of hospital employees. Above, a member of the audience comments on the situation from her perspective.

Saskatchewan

A spokesman for the Saskatchewan Registered Nurses' Association indicates that the association is currently receiving "few requests for assistance in finding nurses for the city hospitals — i.e. Regina, Saskatoon, Moose Jaw. Many new graduates from Ontario have been employed in this province. Small hospitals are not requesting assistance as often as they were a year ago. There are fewer requests that we expedite the admission of foreign applicants. An official from Manpower and Immigration has also noted that there seems to be a fairly generous supply of nurses. The small hospitals are always short of nursing staff unless they have a "captive" supply living in their area. There is little to induce nurses to go to small towns even when the number of job opportunities is small."

Manitoba

In Manitoba, according to the registrar of the provincial association, "things are tight," and likely to stay that way for some time. She sees little chance for a change for the better in the near future and reports that new graduates are expressing a good deal of concern over the possibility that more positions will be cut.

Officials of outlying hospitals in the province say that they are enjoying an unwonted bonanza, with more applications than ever before.

Ontario

The province hardest hit by the austerity program, at least in terms of the number of nurses affected, is undoubtedly Ontario. A mid-Winter government announcement heralding limitations on increases in some areas, freezing of costs in others and actual cutbacks in other areas, was followed by the forced closing of up to 3,000 hospital beds. Estimates of the number of hospital personnel — the bulk of them nurses — who will be laid off range up to 5,000.

Both the Registered Nurses Association of Ontario and Ontario Nurses Association have reacted to the situation with public statements indicating their dissatisfaction with "wholesale and arbitrary reduction of beds and staffing" as a means of cutting health care costs and offering to co-operate with the government in determining means of providing less expensive primary care and eliminating duplication and waste in existing services.

Approximately 4,300 persons are expected to qualify for Registered Nurses' certificates in Ontario this Spring. They will compete for fewer than 200 job openings. An overall reduction of 15 percent in admissions to schools of nursing in the province's community colleges in 1976 has been announced by the ministry of colleges and universities. In the meantime, Doris Gibney, assistant executive director of the Registered Nurses Association of Ontario says, "the situation is really quite acute. Any openings that do exist are for highly qualified nurses." She sees little hope of improvement in the situation in the near future.

Quebec

Jobs are a little easier to find in Quebec than in some other provinces, according to an Order of Nurses of Quebec spokesman, who says that shortages still exist in some specific areas — for example, long-term care and positions in outlying areas. Some exodus of nurses from the province has been noted in the past year, owing partly to concern over provincial language requirements and salary differential. Quebec nurses, whose salaries have been under official review for the past year, anticipate a major increase soon to bring them closer to the national average.

New Brunswick

New Brunswick Association of Registered Nurses' president, Simone Cormier, reports: "In recent months the employment picture in New Brunswick has changed from one of geographic pockets of shortage to the present situation of no extreme shortage. This can be mainly attributed to the immigration of Ontario nurses who cannot find positions in their own province. In filling our vacancies with Canadian nurses, we presently do not have a need for out-of-country nurses.

The closing of 300 hospital beds in New Brunswick will have some impact on the nursing manpower situation, although many nurses will be absorbed into other units or hospitals. As an association, we do have some concern regarding employment opportunities for the upcoming graduates of our nursing schools."

Nova Scotia

Registered Nurses Association of Nova Scotia personnel service consultant, Margaret Bentley, points to several factors affecting the current situation in that province. The number of positions available has dropped sharply under a system of restraints that includes the freezing of staff as of December 31 last year. By late Winter there were only 16 vacancies in the entire province, all but three of these at one hospital. Unemployment Insurance Commission benefits were being collected by close to 200 nurses (not including those on sick or maternity leave) out of the total work force of 5,723 registered nurses in the province.

In early spring, directors of nursing were being swamped with applications from outside the province — (chiefly Ontario). "If restrictions are lifted" according to the RNANS personnel services consultant, "these nurses may get jobs before our students graduate in August. Our fear at the moment is that when these students graduate they will not get employment in N.S."

Prince Edward Island

The Executive Secretary of the Association of Nurses of Prince Edward Island, Laurie Fraser, comments, "it looks as though there will be a few vacancies for nurses this summer. With the relatively small number of staff positions here to start with, and a small turnover rate, there really have never been a large number of positions vacant, and so far here, there have been no bed or staff cutbacks.

I would suggest though that there will be no employment opportunities come Fall, as any summer vacationing staff will have returned and approximately 50 graduates of the PEI School of Nursing will enter the job market. Many will seek jobs in other provinces."

Newfoundland

Newfoundland, which has traditionally been faced with severe shortages of health care workers, is now undergoing a complete reversal of this manpower situation, according to a senior official of the province's department of health. Although temporary shortages may be experienced in some areas during the summer months, he expects that by September there will be sufficient nurses available to staff all of the province's hospital and health services.

In recent months there has been a noticeable increase in applications from nurses in other provinces and most hospitals report a record number of applications now on file. The recent announcement of plans to close 200 beds in 1976 (out of a total of 3,000 in the province) will also obviously affect employment opportunities in the coming year.

Northwest Territories

One cheerful note to end on: the registrar of CNA's newest member association, the Northwest Territories Registered Nurses' Association, points out that there is still a serious shortage of nursing manpower in the North. Canada's last frontier needs *experienced* nurses, capable of working with a minimum of supervision. A word of warning though. Accommodation is tight, unless you're single and willing to live in residence.

If you're interested, contact NWTRNA Registrar, Mary Lou Pilling, Box 2757, Yellowknife, NWT.

Canadian nurses to participate in international seminar

Six Canadian nurses will join seven colleagues from the United States and ten from the United Kingdom at an international seminar in London, England, this summer to compare professional developments and experiences in the three countries.

The event is the third King's Fund Seminar of Nurses, organized by King's Fund College and held in London, July 19 to 23, inclusive. Its purpose is to contribute to the personal and professional development of members of the seminar and, indirectly, to the nursing services in the countries they represent. A report of seminar discussions is also published.

Canada will be represented at the meeting by: Lorine Besel, director of nursing, Royal Victoria Hospital, Montreal; Dorothy Kergin, associate dean of health sciences (nursing) Faculty of Health Sciences, McMaster Health Sciences Centre; Huguette Labelle, principal nursing officer, Health and Welfare Canada; Ada McEwen, national director, Victorian Order of Nurses for Canada; Helen Mussallem, executive director, Canadian Nurses Association; and Shirley Stinson, professor, school of nursing, and division of health sciences administration, University of Alberta.

The central focus of the 1976 King's Fund Seminar will be on leadership. John Garnett, CBE, director of the Industrial Society, will make the introductory address on "The Nature of Leadership."

Three other related areas will be explored during the discussions and speeches that follow. These are: the definition of the role and responsibility of nurses for leadership in a health care delivery system; the emergence of leaders and the evaluation of leadership performance.

The first King's Fund Seminar of Nurses was held in 1972. It was organized by King's Fund College as a direct result of its activities in the area of international exchange of health service personnel. Five Canadian delegates participated in the last seminar, held in London in July, 1974.

News

Ontario nurse-midwives hold annual workshop

The many faces of the nurse-midwife in Canada today were the subject of a recent day-long meeting in London, Ontario. The meeting, which was attended by approximately 100 nurses from southwestern Ontario, was organized by the London and Windsor chapter of the Ontario Nurse-Midwives Association.

A highlight of the day was a panel presentation by seven nurses, each of whom is involved in a different aspect of the maternity cycle. Participants included a family practice nurse from a local medical center, a perinatal nurse from a hospital high risk center, a postpartum nurse, an OB nurse practitioner working in a doctor's office, an inservice coordinator in Obstetrics and Gynecology, a prenatal coordinator in a local health unit and a nurse who had worked in a northern nursing station.

The coordinator of the panel was Mary Cameron of Women's College Hospital, member of the RNAO committee for the expanded role of the nurse, and one of the organizers of the National Committee of Nurse-Midwives.

The activities, roles and functions of the seven nurse-midwives as they described them for the audience, ranged from teaching and support programs for the mother and family before birth, through the actual delivery, up to and including care and support of the mother, baby and family after birth.

Panelists stressed the need for increased continuity of care throughout the maternity cycle and greater involvement of the patient in the health team. Speakers also criticized the tendency in North American society to place undue emphasis on the relatively short time span involved in pregnancy and delivery, compared to the need to provide professional assistance and support throughout parenthood.

Two speakers from St. Joseph's Hospital in London addressed the annual workshop: Dr. Paul Harding, chief of obstetrics and gynecology, discussed "Current Advances in Perinatal Medicine" and Dr. Michael Hardie spoke on "Infection in the Newborn."

Coordinator of a panel discussion on Coping with Parenthood was Karen Kaufman, clinical specialist in maternal child health, McMaster University Medical Centre. Members of the planning committee included Ontario Nurse-Midwives Association members Gaie Haydon, Jan Archer, Mary Mansell, Kay McDonald, and Mary Monoghan.

RNABC members to explore professional attitudes

The idea that the nursing profession acts as "the oppressed majority" will be explored in general sessions of the 64th annual meeting of the Registered Nurses' Association of British Columbia, May 12-14 in Vancouver. The concept being developed is that, while nurses make up a majority of the health care work force, they are dominated by smaller groups and exhibit behavior patterns similar to those of oppressed minorities.

Committee chairman Jo Ann Perry of Vancouver emphasized that the situation could be affecting nursing care, since "our attitudes towards ourselves and others in the profession ultimately influence how we deal with our patients. If we are becoming alienated by the process, our delivery of care can suffer."

The committee's object is to provide a "consciousness-raising" situation to focus members' attention on the problem. Plans for the general sessions include group discussions, a panel presentation and a short talk by a sociologist-anthropologist who would relate typical nursing behaviors to those of minority groups.

Elections will be conducted for new chairmen of RNABC standing committees. Voting delegates will also consider resolutions submitted by districts and chapters, as well as a series of major constitution and by-law amendments. The proposed amendments would restructure the association by establishing a new Labour Relations Division, allow student memberships and change voting representation at future annual meetings.

Edmonton group receives charter

A Pediatric Interest Group that has been active in Edmonton for the past two years recently became chartered as the first affiliate group in Canada of the Association for the Care of Children in Hospitals.

The Association for the Care of Children in Hospitals is an interdisciplinary group that focuses on the psychological and social aspects of the care of hospitalized children and their families. Their objectives are:

- to seek better understanding of the emotional needs of children in medical settings, to foster their well-being, and to develop sound programs of comprehensive care which will support these children and their families;
- to provide a common meeting ground for all those who are concerned with children and their families in such settings;
- to foster high standards of training and competence in all professions working within the pediatric setting;
- to focus the attention of all health workers and the community at large on comprehensive pediatric care;
- to cooperate with other organizations and agencies having related purposes;
- to stimulate and support research related to these purposes.

Membership is open to all those whose professional training and/or professional position is related to the above objectives.



Lavoie Photo Enrg.

For more information, write M. Culp (President), Royal Alexandra Hospital, Edmonton, or Barbara Geyer (Secretary), Charles Camsell Hospital, Edmonton.

ICN asks nurses to describe conflicts

The International Council of Nurses is calling for nurses around the world to submit written contributions for its forthcoming book related to the ICN *Code for Nurses*. The contributions should be real-life descriptions of ethical conflicts they have experienced or observed.

According to Adele Herwitz, executive director of ICN, "as we approach the 21st century, ethical conflicts are of ever increasing concern for the nurse. There is an urgent need for nurses to be strong in their beliefs basic to nursing as expressed in the ICN *Code for Nurses*. This book will provide a unique opportunity for nurses of different languages, cultures and beliefs to share their experiences. Nurses need to know they are not alone in the problems they face and by providing ICN with real-life stories we can help each other."

Nurses are asked to describe an event which illustrates an actual problem situation. The anecdotes should pertain to ethical issues, not legal problems which may be specific only to the laws in one country. The setting and activity may be with patients, with other nurses, with other health professionals or assistants, or with organizations or societies either professional or nonprofessional. The nursing action may be direct patient care, or other activities involving interpersonal relations, teaching, administration or community or professional organization activities.

Nurses should submit the descriptions to the Nurse Project Director, FNIF/ICN Publication related to the *Code for Nurses*, International Council of Nurses, P.O. Box 42, 1211 Geneva 20, Switzerland before 15 August, 1976. Writers of descriptions will not be identified in the publication but names and addresses should be included in case correspondence is needed for clarification.



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News

Smallpox eradication program almost certain to succeed

Laboratories around the world are beginning to destroy their stocks of smallpox virus as the World Health Organization concentrates its campaign to eradicate the disease in the one remaining infected country, Ethiopia.

Some months have passed since the last known cases of *variola major*, the most virulent form of smallpox, were reported, and the milder strain that is still found in Ethiopia exists in fewer than 60 remote villages. WHO officials hope these foci will be eliminated within six months. If they succeed in their goal of wiping out the disease by 1976, it will be the first time man has made a disease extinct.

WHO began its eradication program in west Africa a decade ago. Officials hoped to conquer the disease with a mass vaccination program aimed at immunizing 80 percent of the population of affected countries using jet immunization guns. This strategy was limited by the number of experts required to supervise such a massive campaign, and by some problems with the immunization technique.

The guns frequently broke down and spare parts had to be sent to vaccinating teams; in addition, they were difficult for untrained vaccinators to use. WHO simplified the technique by adapting a short, two-pronged needle originally used to immunize fowl against viral diseases. Then, while working in eastern Nigeria it was discovered, by accident, that the smallpox cycle could be stopped by immunizing only half the population if vaccinating teams concentrated on areas where the disease was most rampant.

By employing a new strategy of detecting and concentrating on outbreaks and following up with a surveillance system to take care of isolated cases, WHO was able to wipe out the disease in South America, Indonesia, Pakistan, Afghanistan and 15 countries in western Africa by October 1974. With this strategy, when an outbreak was detected, infected cases were quarantined immediately and individuals who had been exposed to smallpox were quickly vaccinated.

The countries most recently infected with smallpox were Nepal, India and Bangladesh. But since October 1975, no new cases have been reported in any of these countries, and WHO officials believe that the disease has finally been stamped out in Asia.

Now the only country left to control is Ethiopia, and the 202 cases that were reported in December 1975 were of a much milder strain. Death rates are only 1 - 2 percent compared with 20 - 40 percent fatality rates for *variola major*.

Confirmation that smallpox has been eradicated requires two years of active surveillance after the last known case. After this period, WHO convenes a special International Commission to visit the country and carry out on-the-spot investigations, before they declare the country officially free of disease.

Dr. Halfdan Mahler, WHO Director-General, has said that if eradication of smallpox can be confirmed by 1978, new global agreements could then be reached concerning vaccination for international travel.

It is estimated that world governments have contributed $85 million to WHO over the last decade for its smallpox program.

Clarke Institute creates widows' self-help agency

An outreach program to help the recently widowed cope with this crisis stage in their lives has been established in southern Ontario. The self-help program, called Community Contacts for the Widowed, was developed by the Community Resource Service of the Clarke Institute of Psychiatry in Toronto, as the result of studies indicating that the needs of the newly bereaved were not being met by professionals or the community.

Research by the Clarke Institute and other agencies indicates that widows are a "high-risk" population, particularly vulnerable to psychological, physical and social problems. Young widows, for example, experience three times as many hospital admissions in the year following bereavement as other women of similar age. In one study, 36 percent of suicide victims had been bereaved within five years of their death, and, in another, widows experienced a 12 percent increase in mortality during the first year of bereavement.

Statistics indicate that one in ten Canadian women over 14 are widowed (there are 96,000 in the Toronto area). That their special needs are not being met by other community resources was demonstrated by the overwhelming acceptance rate (88 percent) when widows were approached and offered assistance in the Clarke Institute project.

Community Contacts for the Widowed, fashioned after the Institute's initial pilot project, will be an autonomous incorporated agency based in the community, and will serve Metro Toronto with a central office and four satellite clinics. Through the agency, the newly bereaved will come in contact with widowed people of similar ages who have resolved their own grief. The staff can offer advice for concrete needs (legal, financial, medical, etc.) and are prepared to provide ongoing emotional support. Discussion groups on problems encountered by the widowed, and opportunities for socializing are also offered.

The program is staffed largely by volunteers who have come through a similar crisis and wish to help others in need. However, a small core staff, also widows, will be paid to organize and maintain services in the five offices. All staff, paid and volunteer, are trained by a team at the Clarke Institute.

Enough money has been raised within the community to cover the first nine months of operation. Contributions have been received from a broad range of sources within the community, including major religious denominations, the insurance industry, trust companies, private corporations and Red Cross.

IDRC investigates role of traditional healers

An in-depth study that will attempt to uncover the secrets of African traditional healers in Zaire and possibly integrate them into the country's health services has been announced by the International Development Research Centre in Ottawa.

Traditional medicine in Zaire and, in fact, all of Africa continues to serve a far greater percentage of the population than does modern medicine. In spite of this fact, little is known about traditional healers — their methods, medicines or effectiveness.

The research will take into consideration all aspects of traditional medicine, from medication and anatomy to etiology and therapy. Data on some 250 healers will be gathered through interviews and direct observation for a period of one year. Patients will also be interviewed and samples of the herbs used for treatment will be collected systematically and stored in an herbarium.

Ritual groups function on the basis that the patient is possessed by a spirit, and all of them have in common the fact that a permanent relationship exists between healer and patient. The majority of patients are people who suffer from psychic problems. In each of the groups the patient can proceed through a series of initiations and experiences that eventually leads to graduation as a healer. Groups are largely run for and by women.

The IDRC grant of $133,200 over 18 months provides for training of personnel, compensation fees for the healers, one-day study sessions, production of two films and the services of two consultants in the fields of anthropology and information sciences.

Another $162,325 is being contributed by the National Research and Development Board of Zaire, which will carry out the work, including a survey of all aspects of traditional medicine among specific ethnic groups in rural and urban settings and an analysis of three major therapeutic rites.

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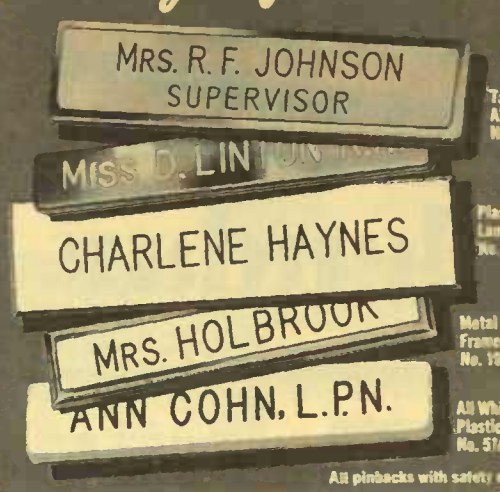
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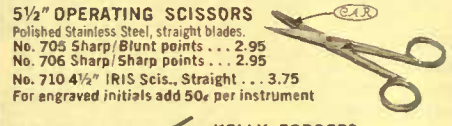
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Calendar

May 26 - 28, 1976
Annual Meeting of the Saskatchewan Registered Nurses' Association to be held at the Coronet Motor Hotel, Prince Albert, Saskatchewan. Theme: "Expectations — Yours and Others." Guest speaker: Dr. Jerome Lysaught, Professor of Education, University of Rochester, Rochester, New York.

May 31 - June 1, 1976
Sixth annual nursing alumni conference at University of Western Ontario, London, Ontario. Theme: Quality of living. Contact: Alumni Committee, Faculty of Nursing, Health Sciences Centre, The University of Western Ontario, London, Ontario N6A 5B7.

May 31 - June 4, 1976
Bilingual Health Care Evaluation Seminar to be held at the University of Montreal, Montreal. All participants are expected to be able to understand both spoken French and English. Information from: Hélène Chauveau, Coordonnatrice du séminaire, Département d' administration de la santé, 2375, Côte Sainte- Catherine, Montréal, P. Qué.

May 31 - June 11,1976
Habitat, United Nations Conference on Human Settlements to be held in Vancouver, British Columbia. *For information, write: Enrique Penalosa, Secretary General, Habitat, 485 Lexington Ave., New York, N.Y. 10017, U.S.A.*

May 31 - June 11, 1976
Course in "Organization and Techniques of Rehabilitation Medicine" at the Calgary General Hospital offered by the Department of Physical Medicine and Rehabilitation and the Department of Nursing Service. Information from Director of Physical Medicine and Rehabilitation, Calgary General Hospital, 841 Centre Avenue East, Calgary, Alberta.

May 31 - June 4, 1976
Multi-Disciplinary Pediatric Rehabilitation Course to be held at Ontario Crippled Children's Centre, Toronto. Information from: Norma Geddes, Education Department, Ontario Crippled Children's Centre, 350 Rumsey Road, Toronto, Ontario.

June 2 - 3, 1976
Seminar: Health Administration Forum. To be held in Ottawa. Information from: Coordinator, Continuing Education Program, School of Health Administration, University of Ottawa, 545 King Edward Avenue, Ottawa, Ont., K1N 6N5.

June 2 - 4,1976
Canadian Association of University Schools of Nursing annual spring conference with Learned Societies is to be held at Laval University, Quebec, Que. Theme: a creative approach to aging. Contact: Colette Gendron, Program Chairman, School of Nursing, Laval University, Pavillon Comtois, Quebec P.Q. G1K 7P4.

June 3 - 4, 1976
Fourth Nursing Pharmacy Workshop to be held at Red Deer, Alta. Theme: Cardiovascular Disease and Patient Management. Information from: Continuing Nursing Education Division of Continuing Medical Education, Clinical Sciences Bldg., University of Alberta, Edmonton, Alta. T6G 2G3.

June 14 - 17, 1976
Workshop on the borderline student nurse to be held at University of Western Ontario, London, Ontario. Information from: Summer School and Extension Department, University of Western Ontario, London, Ontario N6A 5B8.

June 16 - 18, 1976
Annual convention of the Canadian Hospital Association to be held at the Chateau Laurier, Ottawa, Ontario. Information from: Canadian Hospital Association, 25 Imperial Street, Toronto, Ontario, M5P 1C1.

June 19, 1976
Kitchener-Waterloo Hospital reunion for Class of 1966. Information, from Hilary Bowers 196 Lyndhurst Drive, Kitchener, Ontario, N2B 1C1.

October 27 - 29, 1976
Annual general meeting of the Order of Nurses of Quebec to be held at the Queen Elizabeth Hotel, Montreal.

Input continued . . .

Slip in time...

There is one mistake in the article on Halifax (February, 1976) which I rather object to as it was not written this way in my copy. It is not "The Order of Good Cheer" — it is "The Order of the Good Time" — this is the official name.

I like the new format — it's quite exciting and immensely different — almost takes a bit of getting used to. I particularly liked your January editorial! and I do hope you're having fun.

— Dorothy Miller, Public Relations Officer, Registered Nurses' Association of Nova Scotia.

Death with dignity

Much has been heard recently, on T.V. and in the newspapers, about an individual's right to "die with dignity"....

There is a great difference between positive euthanasia and passive euthanasia; the latter is simply the withdrawal of extraordinary treatment, without which the patient would die a natural death with nature taking its normal course.

The answer may be to have those who wish to do so write out a statement to the effect that if ever their life reached a point where it must be artificially sustained by extraneous mechanical means then they would wish to be allowed to die with dignity and peacefully....

— Alice Tester, R.N., White Rock, B.C.

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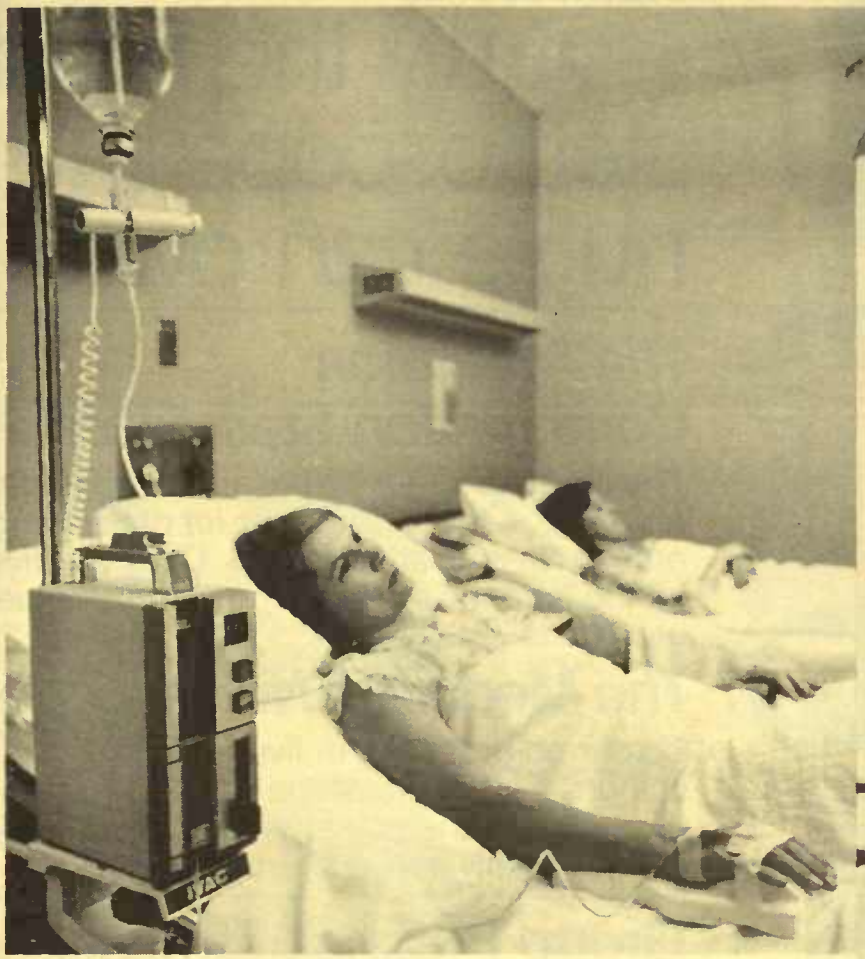
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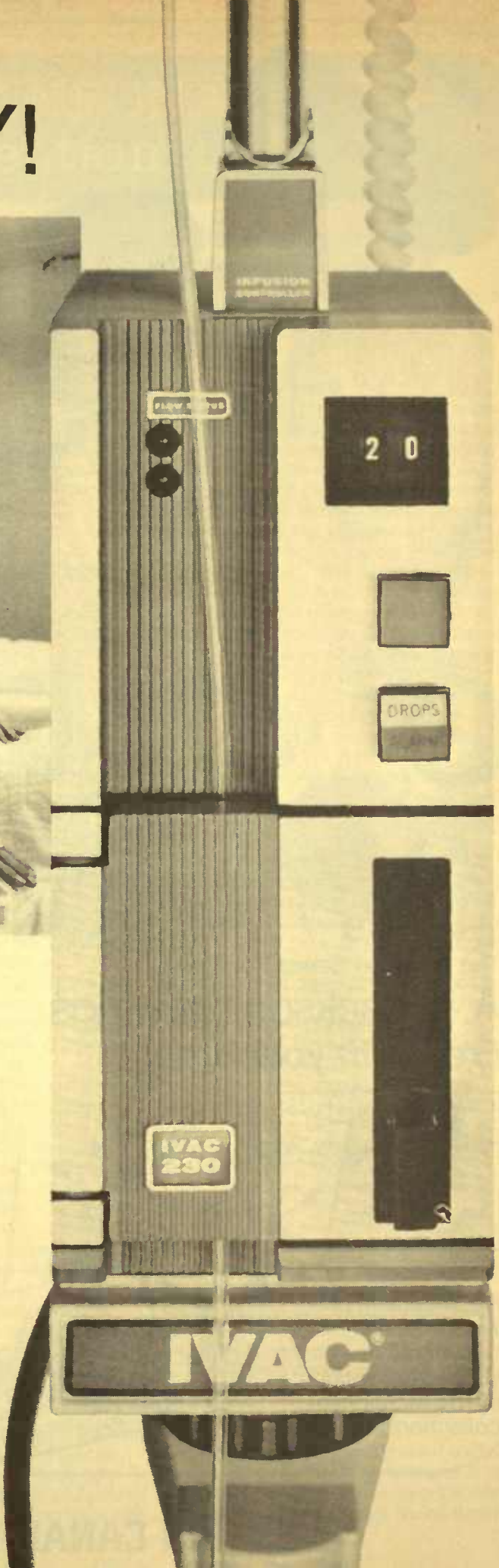
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Coggin, S. : Modern I.V. Technology. Modern Hospital, March, 1973

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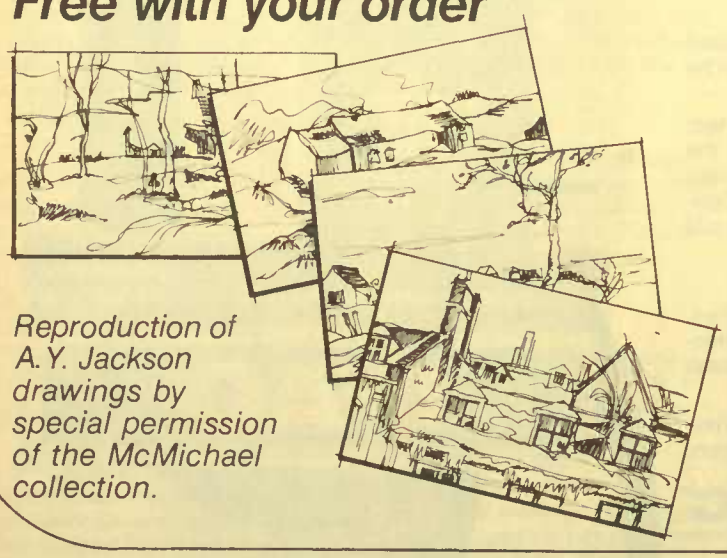
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TRANSPORT OF NEONATES – a matter of prevention

Transport of the sick neonate by personnel unaware of his special needs may render the journey so hazardous that all efforts at the referral hospital become futile. The authors demonstrate that careful nursing and adequate preparation *before and during* transport can minimize the risks inherent in such a journey.

Moya Johnson and Janice Gash

Moya Johnson, R.N., B.Sc.N., is clinical instructor in neonatal nursing and Janice Gash, R.N., B.Sc.N., is research nurse in neonatal transport at The Hospital for Sick Children, Toronto, Ontario.

Moya Johnson







Janice Gash

Every year, approximately 12,000 "high risk" infants are born in Ontario, many of them in hospitals without facilities for the necessary intensive medical and nursing care. If they become critically ill, these infants must make a potentially hazardous journey to a neonatal intensive care unit in another facility. The story is the same in other provinces.

Some units have a transport team (usually consisting of a neonatologist and a specially trained nurse) and are equipped with a transport incubator, cardiac and temperature monitors, and complete resuscitation equipment. The team tries to stabilize the baby's condition before transportation, and provides intensive care throughout the journey to the referral center. Unfortunately, few isolated areas and not all cities have access to such transport teams, and in some instances there is no one with experience in neonataology who can accompany the sick infant. Also, a team may receive more calls than it can handle at a given time or, because of bad weather, may be unable to reach the infant.

It happens sometimes, then, that a nurse with no neonatology training has to care for a sick newborn infant before and during his transfer to a referral center.[1] This makes it essential that all nurses in outlying hospitals with maternity beds be aware of the special problems of the sick newborn[1,2,3] and of the measures necessary for their safe transport. All too often there is a temptation simply to place the critically ill neonate in an incubator and dispatch him as quickly as possible — a well-intentioned but misguided approach.[1]

This report provides some guidelines for nurses to help them understand the special requirements of sick newborn infants. The nurse should first of all obtain all available information concerning the infant in her charge — not only the disease or defect from which he suffers (its pathophysiology and possible complications) but also the maternal and family history, the gestational age, and general condition. Ideally, the nurse should have had previous contact with the baby.

Thermal control

It is of paramount importance to prevent loss of heat in the newborn. He produces heat by body metabolism and muscular activity and cannot shiver in response to cold, so must rely on nonshivering thermogenesis for heat production. This involves energy generation in brown fat (a highly vascular deposit of fat chiefly between the shoulder blades and around the neck). This tissue's ability to produce heat as a metabolic adaptation to cold is greatest in the newborn. However, the greater the demand for its activity the more quickly it is depleted.[4] Because illness depletes his energy, depressing his metabolism and decreasing body activity, the newborn may be unable to produce enough heat to maintain his body temperature.[5]

Cold stress is traumatic, even life threatening. Mortality rates in small, premature infants increase markedly with each degree of temperature loss[1,4] hence the importance of preventing heat loss.

Heat is lost from the body through conduction (to a colder object in contact with the body), evaporation (fluid changing to vapor on the body surface), convection (to cooler air currents), and radiation (to a cooler, solid object not in direct contact).[5] In an air-conditioned case room or nursery, an exposed, wet, sick baby can lose a great deal of body heat very quickly.

Heat loss can be prevented in several ways, as shown in *Table I.* These techniques do not, however, increase an infant's temperature, but only minimize loss of body heat. Therefore, heat shields, Saran, bubble plastic, blankets, and foil should be used only on *warm* babies.

Cold stress may result in the following complications:

- decreased energy stores, leading to an increased likelihood of hypoglycemia;
- decreased activity of enzymes concerned in production of surfactant;
- increased oxygen consumption;
- increased metabolic acidosis, if there is accompanying hypoxia or shock;
- increased risk of kernicterus in jaundiced infants;
- increased risk of hemorrhage.

Before transit: If efforts to prevent cold stress have been unsuccessful, measures must be instituted immediately to rewarm the infant. A normothermic environment during transfer

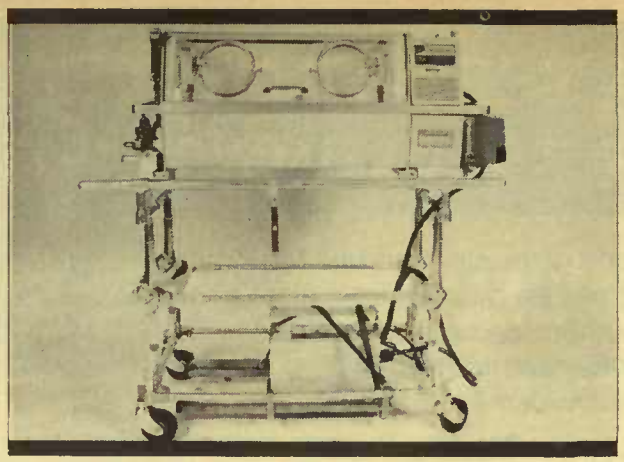


Figure 1 — Transport incubator with power source for light, heat and air-flow, as well as independent oxygen source.

enhances the chance of survival, and is much easier to achieve with proper equipment at a base hospital before transit. In view of the survival factor, the extra time taken to rewarm the infant before transit is not wasted.

A radiant heater provides the most effective and safest means of rewarming a hypothermic infant. Many commercial models are available, most of them servocontrolled. The temperature gauge should be adjusted to about 1°C — 2°C above the infant's skin temperature. Rewarming should proceed slowly; too rapid rewarming can result in apnea and shock. An incubator is used in conjunction with radiant heat as neonates are less able to absorb heat by convection. An incubator may be used alone for a slightly cold baby whose temperature is 35.5°C — 36.0°C. The servocontrol should be set to maintain skin temperature at 36.5°C. If the incubator is in a cold room or near an outside window much of the infant's body heat may be lost by radiation through the incubator shell; hence the temperature of that area of the nursery or case room is important.

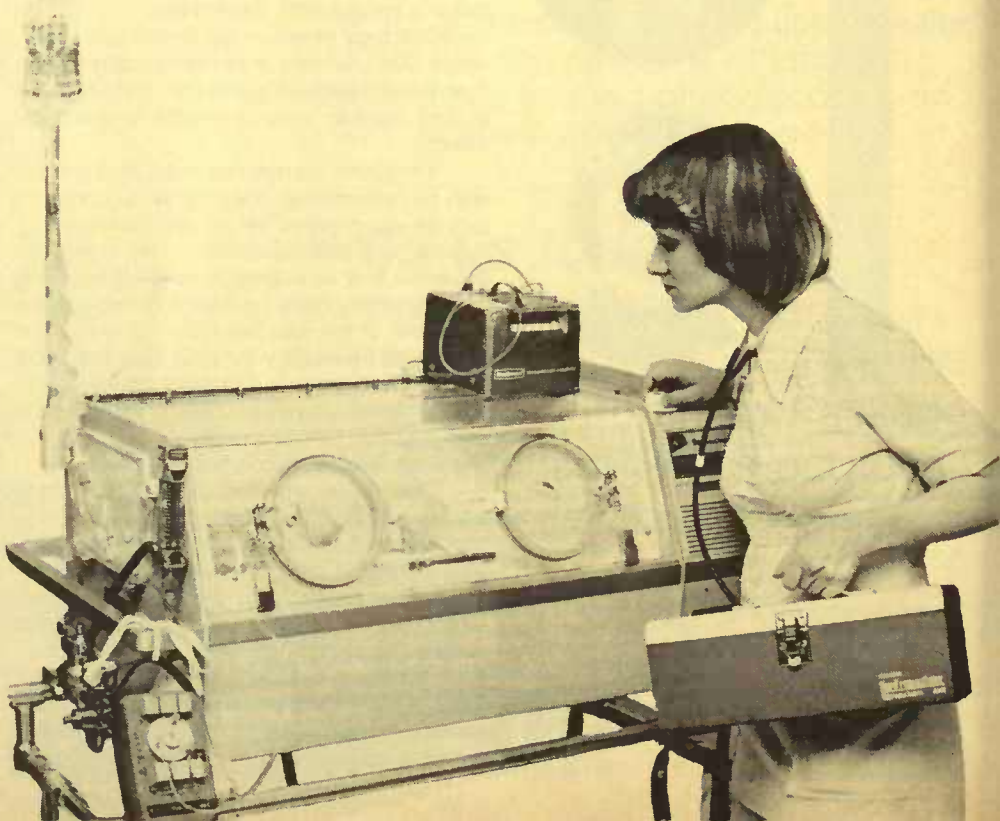


Figure 2 — Rectal temperature of baby is checked while he is lying on bubble plastic. Note open N/G tube in place and suction mucus trap at hand in incubator.

Figure 3 — Nurse and baby ready for transport. Note: I.V. on pole with I.V. 'Holter' pump for continuous infusion; oxygen analyser; adjustment of temperature control; baby wrapped in bubble plastic with N/G tube in place. Nurse, with stethoscope around her neck, holds case containing emergency equipment.

During transit: The transport incubator must be preheated *(Table II)* and must be capable of maintaining the appropriate temperature (in accordance with baby's weight) by its own power source. A specially designed model is the apparatus of choice. Nursing procedures should be carried out through the portholes, to minimize escape of heat.

Bubble plastic is an ideal insulator for transport, permitting a clear view of the infant. When warmed blankets are the only available means of conserving body heat, the nurse must be even more vigilant to compensate for limited access and visibility.



Respiratory care

Airway: Maintenance of a clear airway is essential. Most infants require only gentle suctioning of accumulating mucous secretions; but some may need intubation, either prophylactic (in case of apnea) or for respiratory complications. The endotracheal tube should be securely taped to maintain its proper position, and suction catheters should be used to maintain its patency. Air entry is checked regularly with a stethoscope, over both lung fields. If the breath sounds are diminished, the chest does not visibly inflate; or if cyanosis develops, the tube may be out of position or (rarely) blocked. Vocal sounds from the infant will indicate that the tube is not in the trachea. If you think the tube is dislodged, remove it, and continue ventilating by mask. If you think the tube is blocked, suction it.

Since the motion of the ambulance could cause the infant to aspirate his stomach contents, the stomach must be emptied before he leaves hospital.

Oxygenation: Having established that the airway is clear, the nurse should attend to oxygenation. The inspired oxygen concentration may need adjustment in infants with respiratory disorders. Hypoxia (insufficient oxygen to the tissues) can result in focal necrosis and permanent brain damage. Hyperoxia (too much oxygen) can cause blindness in premature infants by disrupting normal developmental patterns of the retinal blood vessels.

Accurate assessment of individual oxygen needs is the only sure way to prevent deleterious oxygen effects. An arterial O_2 pressure (PO_2) in the range of 50 - 70 mm Hg is ideal for term or premature neonates. If blood-gas measurements are unavailable, the infant's color can be used as a rough guide. The flow of oxygen (liters per minute) is at best unreliable, as the O_2 concentration (the amount breathed) will vary with leaks, the amount of ventilation, type of equipment, and method of administration. The O_2 concentration required for each patient must, therefore, be determined, and the actual value must be measured and maintained at this appropriate level.

A guide for oxygen administration, if blood gases are not known, is as follows:

1 Place the infant in 40 percent oxygen and assess his color.

2 If he is cyanotic, increase O_2 concentration by 10 percent increments until he becomes pink; then reduce it by 5 percent.

3 If he is pink in 40 percent O_2, decrease by 5 percent decrements until cyanosis appears; then increase by 5 percent.

It should be borne in mind that oxygen requirements may change during transit. Therefore, constant evaluation is necessary until arrival at the neonatology unit (an O_2 analyzer is a valuable aid).

Table I

Methods of Limiting Heat Loss

Equipment and Method	Function	Process leading to heat loss
Incubator	Provides flow of warm air	Convection
Environmental humidity	Reduces loss of fluid from body surface	Evaporation
Drying	Prevents heat loss from evaporation of amniotic fluid	Evaporation
Heat shield (Plexiglass) over infant inside incubator	Decreases heat radiation through incubator shell; insulates the infant	Radiation and convection
Bubble plastic* double-layer plastic wrap	Insulates the infant	Radiation and convection
Saran: single-layer plastic wrap	Prevents liquid → gas change at body surface	Evaporation
Warm blankets, aluminum foil	Insulate the infant *(N.B.: Impair view of the infant; therefore, of limited value)*	Convection and radiation
Heating pad, hot water bottle	Warm surface in contact with baby *(N.B.: May cause burns if temperature difference too great)*	Conduction

* Aircap; Brent Manufacturing Ltd., Malton, Ontario.

Table II

Incubator temperature during transport of sick neonates

Body weight	°C *Incubator temperature**
1,000 g	36 - 37
1,001 - 2,000 g	35 - 36
2,001 - 3,000 g	34 - 35

* Temperatures listed are guidelines only. Rectal temperature should be monitored every 10 to 15 minutes, and the incubator temperature adjusted accordingly.

Ventilation: Even though an infant breathes spontaneously and is appropriately oxygenated, he may not be properly ventilated because, in addition to inhaling oxygen, he must exhale carbon dioxide. Rapid, shallow respirations are less effective than regular, deep respirations in ridding the body of CO_2, and a decreased respiratory rate may create a buildup of CO_2. Since breathing uses energy, a tachypneic infant is more likely to tire, and may even become apneic. Rates of 40 per minute for a term infant, and 40 to 60 for a premature one, are appropriate. Rates over 100, or less than 30 per minute, which are likely to be inefficient, may be supplemented with intermittent bagging (e.g., for tachypnea, bag for 5 minutes each half hour). When the rate is markedly diminished, bag continuously at 40 - 60/ min in conjunction with respirations.

Before bagging by mask, aspirate the stomach with an orogastric tube, which must then be left open and in place to allow for decompression of accumulated air.

Observe the infant for other signs of respiratory distress, such as grunting, indrawing, and flaring of the nostrils on inspiration. These, in addition to tachypnea and cyanosis, are signs of lung disease; record the time of onset, degree of severity, and change.

Apnea: It is normal for neonates to breathe irregularly. However, cessation of respiration for longer than 20 seconds and/or accompanied by bradycardia, with or without cyanosis, is considered to be *apnea* and requires treatment. Apnea may be due to many factors, including overheating, immaturity, neurologic damage or depression, airway obstruction, CO_2 retention and hypoxia, hypoglycemia, or sepsis.[6]

If an infant stops breathing, he may respond to stimulation during the first 20 - 30 seconds of apnea. Stroke the abdomen gently and flick the soles of his feet. If there is no response, quickly suction the naso- and oropharynx. In addition to removing mucus, this may stimulate a gasp, followed by resumption of respiration. *Suctioning must be brief:* if prolonged it may result in hypoxia and pulmonary collapse.[2] If there is still no response, ventilate the baby with a bag and mask at 60 per minute with the requisite oxygen concentration. Give 5 or 6 inflations; if the color has improved and the heart rate is not below 120 per minute, pause to see if spontaneous respiration is resumed. In the continued absence of respiration, continue bagging and stimulating until respiration begins.

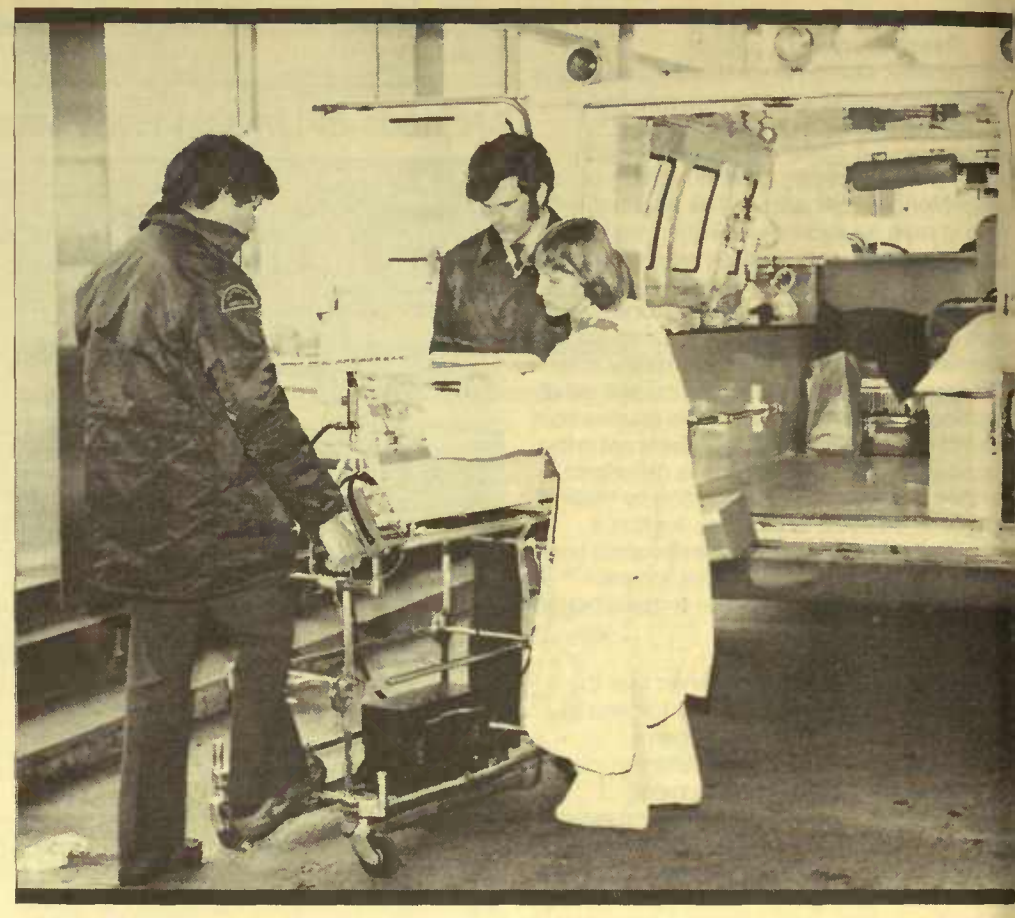


Figure 4— Nurse adjusts oxygen flow on transport incubator as incubator stand is lowered to fit into ambulance.

Metabolic homeostasis

Hypoglycemia: Low blood sugar in infants is most common in those who are small for date and/or premature; cold-stressed, septic, and asphyxiated; babies of diabetic or toxemic mothers; and those with Rh incompatability. A glucose level of less than 40 mg/dl, especially if giving rise to symptoms, may result in irreversible brain damage. Therefore, it is wise to check the blood sugar level with a heel-prick Dextrostix (Ames Laboratories) or a laboratory test before transport.

The infant should be observed for signs of hypoglycemia, including:
— jittery state, twitching, convulsions, exaggerated Moro reflex;
— apathy or lethargy;
— apnea and/ or cyanosis; and
— poor feeding, decreased sucking reflex.

If intravenous therapy is given to correct hypoglycemia, the flow must be kept constant. A battery-powered I.V. pump will help to achieve this.

Acid/base balance

Events such as hypoxia, hypothermia, hypercapnea, cold stress and hypoglycemia, and conditions stemming from inborn errors of metabolism, may alter the blood pH. This may severely disrupt the metabolic activity of cells. Therefore, it is important to stabilize the acid/base balance before transport and to try to correct or treat the underlying cause. (Normal blood-chemistry values are given in *Table III.*)

Fluid balance and Intravenous therapy

It is dangerous to overload the circulation with fluid, which can easily happen in a small, premature baby when the I.V. line is unobserved for even a short while. The fluid requirement for a newborn or premature in the first 2 to 3 days of life is approximately 75-150 ml/kg of body-weight per day (for a 1 kg baby the I.V. rate should be 3 - 4 ml/hr).

It is difficult to maintain an I.V. drip in a moving ambulance due to motion, lack of height for the pole, and the patient's activity. The I.V. line must be securely fastened, and the site visible for assessment. This line may be invaluable for emergency administration of medication, both in transit and on arrival in the unit, hence it must remain functional.

Ambulance and equipment

The ambulance should have its own power source, unaffected by engine r.p.m. (12 volt DC battery is best). The cab must be heated to at least 26°C *before* the incubator is placed in it. Heat turned on at the time of pick-up is ineffective, as the cool inside walls of the ambulance permit loss of radiant heat. The oxygen and suction facilities must be in working order.

The transport incubator has specific requirements. It should have its own power source for light, heat, and airflow and also an independent oxygen source for use between ambulance and hospital, or when the ambulance supply has been depleted. The ambulance power supply must be used for the journey as most incubator batteries have a reserve of only 1 - 2 hours and take many hours to recharge. The incubator should be fitted with a thermometer and thermostat control. The light source must be adequate for clear observation of the infant's color and condition; this can be supplemented by using a strong flashlight.

The nurse requires a good working knowledge of the incubator, including how to control the O_2 concentration in the baby's environment. During transport, the baby must be securely strapped down within the incubator.

The best incubator is only as good as its operator.

Every transport should be provided with a kit containing 1) bag, 2) mask, 3) mucus-collection trap and suction catheters, 4) stethoscope, 5) thermometer, 6) oxygen analyzer, and 7) flashlight. The quality of care is enhanced if, in addition, the kit contains drugs for emergencies and an I.V. pump.

Special conditions

Certain conditions warrant additional preparations for transport:

Pneumothorax: A chest tube is imperative, preferably attached to a one-way safety valve (Heimlich valve, Bard Parker Co., Rutherford, N.J., U.S.A.) or underwater seal. It must not be clamped.

Diaphragmatic hernia: The infant's head and trunk should be elevated, to relieve thoracic pressure. Since gastric distension would increase intrathoracic and embarrass respiration, an open oro- or nasogastric tube is mandatory. Endotracheal intubation is recommended in case ventilation is required in transit, as mask ventilation increases gastric distension.

Choanal atresia: An oropharyngeal airway, securely fastened in place, is essential.[4]

Tracheo-esophageal fistula: (In 95 percent of cases a fistula joins the lower esophagus to the trachea). These infants should be placed upright, so that gravity will prevent aspiration of gastric contents into the lungs. The upper pouch must be suctioned continually; this can be readily accomplished with a feeding tube and syringe.[2]

Exposed abdominal or neural contents (omphalocele, gastroschisis, myelomengingocele, and bladder extrophy): Wrap the defect in warm, sterile, saline dressings, and further cover it with plastic wrap to prevent drying. (Vaseline gauze is not advised). Treat the entire infant with sterile technique (gloves, sterile linen, etc.).

Table III

Normal blood chemistry values in the newborn

Blood pH	7.34 - 7.45
PaO_2 (mm Hg)	50 - 70
$PaCO_2$ (mm Hg)	35 - 40
HCO_3 (mEq/liter)	19 - 22
Base excess	−4 to +4
Blood sugar (mg/dl)	45 - 115
Serum calcium (mg/dl)	8 - 10
Serum electrolytes (mEq/liter):	Na, 140; K, 4; Cl, 100-105

Nursing memo

Before departure:

1 Ensure that the infant's identity band is securely attached and that the details are correct.

2 Check that you have the following documents:

— maternal and family history (the neonatology unit may supply special transport forms for referring hospitals).

— maternal and cord blood (5 ml of clotted blood of each specimen).

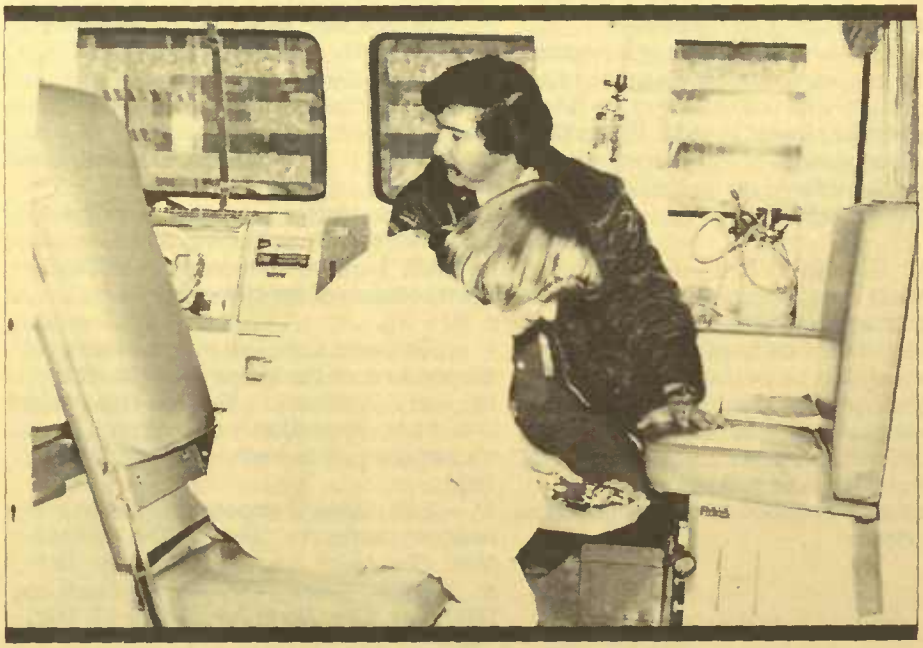


Figure 5 — Nurse plugs incubator power line into ambulance power supply.

— test results, radiographs, and so on.
— photostats of nurses' notes and doctor's letter.
— signed parental consent.

3 Scrub hands and arms for 3 minutes before handling the infant.

4 If there is time, talk with the parents and allow them to see and touch their baby: your reassurance at this time will do much to allay their fears about the baby's illness.

5 Just before leaving, check:

- Infant — clear airway; appropriate O_2 concentration; correct body temperature; empty stomach; correct blood chemistry; and treat special condition(s).
- Equipment — incubator; ambulance; emergency equipment; and oxygen supply.
- Full data on baby and mother, and blood samples.

During transport: If preparation is carefully carried out, the infant will be in a relatively stable condition and transit should require no undue haste. Upon entering the ambulance, adjust the voltage control and plug in the incubator to the ambulance power outlet. Change the oxygen source from the incubator to the ambulance cylinder and analyze the concentration. Observe the baby's condition, color, and activity and record his body temperature. Check the I.V. flow rate and infusion site.

After this initial review, the journey can begin. Throughout transit the nurse must constantly observe and monitor for changes in condition, take appropriate action, and record vital signs and other pertinent information. Lighting may be inadequate for accurate assessment, and noise levels may preclude adequate monitoring of apical heart rate and air entry. If uncertain of the baby's condition, ask the driver to halt the ambulance at the side of the road for as long as necessary.

If medical advice is required or a medical emergency occurs, use the ambulance radio to contact the referral unit or instruct the driver to proceed to the nearest hospital. If possible, inform the neonatology unit of your impending arrival, and the infant's current condition, via the ambulance radio.

On arrival: However brief the journey from ambulance to ward, there must be continuity of observation and care. The incubator power and oxygen should be used; all necessary equipment should be available; monitoring should be continued. The transporting nurse should remain in the referral unit for a short time, to answer questions about the infant's history and his condition during the journey, and to obtain information for the parents and referring doctor.



Figure 6 — "Hope" bag and mask applied over baby's face for ventilation. Note bubble plastic, N/G tube open to allow for decompression of the stomach.

Conclusion

Special requirements and precautions are necessary for safe transportation of sick newborns. With proper care, further deterioration in a sick infant's condition during transit can be avoided. In fact, with proper attention to apparently minor details, the nurse will, in many cases, be rewarded by seeing her patient's condition improve.

References

1 Chance, G.W. Transportation of sick neonates, 1972: an unsatisfactory aspect of medical care, by... et al. *Canad. Med. Ass. J.* 109:9:847-851, Nov. 3, 1973.

2 Segal, Sydney ed. *Manual for the transport of high-risk newborn infants; principles, policies, equipment, techniques.* Sherbrooke, P.Q. Canadian Pediatric Society, 1972. 198 p.

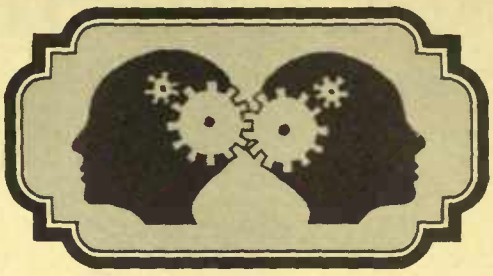
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connection



The Handmaiden is NOT Dead

Jo Logan

The handmaiden is not dead, despite what you read in current nursing literature. She is alive and well and residing in the hearts of most physicians. This fact presents a problem to many new graduates, who are unaware of the discrepancy between how nurses think they should practice nursing and how physicians think nurses should nurse.

Most physicians still feel the word nurse and the word handmaiden are synonymous. Whether this fact is openly admitted or not, it becomes obvious — often painfully so — to any nurse who tries to slip out of her traditional role while working in a traditional setting. She is faced with a reaction on the part of the doctor which ranges from frank outrage to condescending amusement. Not only does the physician emphasize the technical skills of the nurse but he frequently and openly blocks any of her attempts to function in a way other than what he considers to be her traditional role. This difficulty will increase as nursing education and nursing service continue to move toward a different type of nursing based on the belief that nurses have a major contribution to make to the health care of this country.

Because of current and future changes in nursing practice, nursing educators have made necessary revisions in the curriculum and many traditional attitudes and skills have been replaced. One concept that has been dropped from nursing education is that of "handmaidenism." At first glance this would seem to be a step in the right direction but without the attitudes and skills of the handmaiden, the new graduate cannot play the "doctor-nurse game"[1] that is necessary for survival in most work situations. This is especially true in hospitals, where most new graduates begin their career.

Stein describes an important aspect of the doctor-nurse game as follows: "The nurse is to be bold, have initiative, and be responsible for making significant recommendations, while at the same time she must appear passive."[2] Nurses are being taught to make judgments and act on their own conclusions but they are no longer taught the need to be passive. Combine this change with the effects of the women's movement, and the result is a new graduate who thinks of herself as a novice on the health team but with an equal and unique contribution to make as a nurse. Immediately, the novice practitioner must work with a physician who has a very traditional frame of reference regarding the nurse. The new graduate is quickly aware of how much she needs the doctor in an acute care situation but she does not know the rules involved in keeping this relationship functioning smoothly. This fact was clear during a recent orientation program this writer attended. Three-quarters of a group of new, two- and four-year graduates had had a confrontation with a physician before the three-week orientation was finished. They expressed astonishment because they did not understand where they had gone wrong. In most cases the difficulty stemmed from their inability to play the doctor-nurse game; they were just not aware of the nurse in a handmaiden role.

Just as the neophyte becomes aware of her dependence on the physician in the clinical setting, the experienced nurse becomes aware of the power held by the physician in most institutions. If nurses must rely on physicians, then it seems prudent to consider their frame of reference. Any changes made in nursing practice will be slow, hard-fought gains until the relationship between the nurse and the physician changes.

Obviously the change in this relationship should be initiated by experienced registered nurses, rather than new graduates. The priorities of the novice are different, and revolutionizing nursing practice is not necessarily high on their list. The inexperienced graduate does not have the self-assurance of the seasoned nurse nor the credibility so necessary to work any changes with physicians. It is difficult to change the rules of a game if you cannot play the game.

There are a few examples of physicians and nurses cooperating to change the rules of the game[3] but these models are rare. Most of the changes will be accomplished in a less direct manner by experienced nurses who play the game skillfully but are aware of the limitations of this relationship and consciously set goals for a new type of nurse-doctor interaction. The efforts of the experienced nurse, supported by the impetus of other social forces[4] will create a new and, hopefully, more honest relationship.

Considering that nurses need physicians, and that it is unlikely the new graduate will be in a position to change the nature of this dependence, nursing educators must retain handmaiden skills in the curriculum until they are not so urgently required. I do not suggest that a formal course "Handmaiden 204" for three credits be offered or that this concept slip back into the hidden curriculum, but certainly students should be made cognizant of these attitudes and skills. The handmaiden should be presented, not as a way of life, but as a skill to be utilized until it is no longer necessary.

To ignore this need and assume that nurses can practice in a nontraditional way without first changing the nature of the nurse-physician relationship is naive. The handmaiden *must* disappear forever but this can only happen gradually as nurses evolve their new role to replace her.

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WHAT DOES "THE QUALITY

For criminologist Marie-Andrée Bertrand, truth is at the center of life.

This year, the Canadian Nurses Association is encouraging serious thinking, and — who knows? — possibly even action on the "quality of life" in Canada. This is a vast concept; it is also a subject which is very difficult to gauge precisely and one which each person must deal with on his own terms. Indeed, sociologists, economists and political scientists have recently identified several scores of possible "quality of life" indices. These are factors which may be termed meaningful scientific or statistical clues in which some confidence can be placed when considering the notion of quality of life, in a given and related sociocultural context.

In fact, there are economic indices, such as average annual income compared to a cost-of-living index. There are social indices, such as the organization of human and work relationships. Political indices may include, among others, strength of democracy, and power of individual and group expression.

It is through these types of factors that members of one society can be judged to be living in more human conditions than members of another society. After all, "quality of life" involves those conditions of existence which let us be more human, more totally "ourselves," to be more involved citizens, and to be the most competent and professionally efficient individuals we possibly can be.

Some years ago I had the pleasure of teaching members of your association on several occasions. It is in the context of these earlier and very enjoyable meetings, that I remember who you are, what your way of life is and what your problems are — so that I am in a better position to discuss the quality of life with you. Of course, my own current interests also have a bearing on these considerations. I refer specifically to the four years I spent as a member of the Federal Commission of Enquiry into the Non-Medical Use of Drugs, an experience which will, I hope, tie in with some of your own medical interests as they relate to the quality of life. In addition, as a criminologist, I will be referring to certain conditions of mankind — of equity, of justice —which I feel must be redefined in order to become more meaningful in our society.

At the Le Dain Commission, after three years of hearings in 100 Canadian towns, three years of research, meetings and writing and editing, I finally came to understand the reality that 80 - 85 percent of all known diseases have no known cure and that doctors are too often satisfied with recognizing symptoms and relieving them.

I also learned that several drugs which the Canadian population consumes *by the ton* (like drugs with a codeine base) or by the hundreds of thousands of pounds (barbiturates, minor tranquilizers) are just as dangerous as the so-called illicit drugs such as cannabis. I saw the representatives of the major pharmaceutical companies come to defend *their* Valium and *their* Librium, over the products of other companies, assuring the Commissioners that *their* tranquilizers have fewer side effects than the others, and present less risk of creating tolerance and drug dependence.

In an intensive study situation such as this, the quantities of lies and half-truths that were discovered day after day shocked me. *For me, the quality of life in the health field is related to truth.* It is related to the truth about the relative impotence of medicine; about the effects of drug therapy; about the fact that certain diseases are fatal; about the necessity of suffering, which cannot always be avoided. The quality of life of certain women I know who drag out their neurotic anxieties in psychotherapy, in depression, certainly is very poor. I do not think that they are truly alive. These women are trying not to see what they are and trying not to die.

On the other hand, as a criminologist and in a different but not completely dissociated field, in my work on civil liberties committees, I have been especially concerned with the *definition* of crimes. When I say that I agree with the Criminal Code of Canada that murder is a very serious crime, I certainly am not saying that murder is the only serious crime. As I see it, racism, sexism, exploitation of the poor, and air, water and noise pollution are all extremely serious crimes, as serious as murder and much more serious than offences against property. Indeed, humans can be left with physical well-being, even after they have been deprived of their dignity through racism; their autonomy and freedom, through sexism; their chances for a decent life, through exploitation of the poor; or their environment, through pollution. As long as the attitudes of those who are engaged so ferociously in the selfish pursuit of unbalanced priorities remain so static as to exclude real crimes like thes from our criminal laws and our value system the quality of life certainly will continue to be myth. Compared with the immense social injustices noted above, nonviolent theft can hardly be considered a misdemeanor, yet, thieves are often imprisoned while the real criminals, such as the merchants who encourage persons with insufficient income to spend far beyond their means, remain free

If a person's race, language, sex or salar does not give him or her access to facilities t which the majority of Canadians have a righ then, racism, sexism, and exploitation of th undereducated and poor *do* exist in Canada' society. These crimes are major obstacles t the quality of life, both of those who commi them, and of their victims. They spring from and feed on greed, profit at any cost, the exploitation of man by his fellow man, institutionalized scorn for people of other races, women and children.

As long as the medical profession and their colleagues, the pharmacists, will not permit the destruction of the myth that they have fostered ... as long as they persist in perpetuating this myth by writing and filling prescriptions that do nothing to improve the health of their patients ... as long as the medical profession refuses to admit its impotence in the treatment of 80 percent of recognized diseases ... it is hard to see how th quality of health and life of Canadians can b improved.

Nurtured as we have been, by lies and half-truths, and stuffed with medicines, toda we are becoming pitiable dazed half-citizens half-persons, sheltered, we think, from suffering, anxieties and insomnia ...

Marie-Andrée Bertrand, who received her M.A. in Social Work and in Criminology from the University of Montreal, obtained her Doctorate in Criminology from Berkeley University in California. She is associate professor in the School of Criminology at the University of Montreal.

From 1969 to 1973 she was a member o the Federal Commission of Enquiry into the Non-Medical Use of Drugs. She is currently working on a book that will discuss the relatively minor involvement of the female sex in crime.

OF LIFE" MEAN TO YOU?

Convention planners, Glenna Rowsell and Lorine Besel, tell why the association chose this theme.

This year's convention theme, according to Glenna Rowsell, is a highly individual topic that reflects many aspects of life. In its entirety, the program is intended to present a global view of questions about the quality of life. "We want to encourage nurses to see themselves, not just as professionals, but also as citizens who are aware of the world around them."

One evening during the convention will be devoted to music and art. "This is important," explains Rowsell, "because the nurse is often so bogged down in her duties that she ends up doing the same thing day after day and sometimes forgets about all the other important and enriching experiences that life has to offer."

Rowsell hopes the convention will motivate individual nurses to look for deeper implications of living, not only for other people but also for themselves. She believes this will help each nurse to see herself and her contribution to society more clearly. "There are many questions that nurses should be asking themselves but the most important is: Do I really identify with the effect that the nursing profession has on society and does that relationship have anything to do with improving the quality of life?"

Rowsell feels that nurses are becoming too far removed from their primary function. "The administrative ladder is taking us further and further away from where we should be — at the bedside where the real rewards of nursing are found."

"So many young nurses say, 'I'm just a staff nurse.' Unfortunately, this attitude is becoming more common among nurses of all ages." The program chairman hopes the theme of the convention will help nurses to develop an increased awareness of the needs of the people they care for. "We must recover our sense of values," she says "and orient ourselves towards human beings, not efficiency."

Lorine Besel says "the quality of life" was chosen as the theme of the convention because "as nurses, we have a particular responsibility to see how patients are affected by their work and environment." She feels it is unfortunate that the nursing profession has not yet taken much responsibility in this area. "Our concern has been mainly with sickness. We need to become involved at an earlier stage in order to help the population gather enough data to identify the real causes of health problems."

When asked to give a more precise definition of the nurses' role, she stated that nurses should be activists in helping the population formulate action plans for the study of specific problems. "They should also speak out in public, both as professionals, and as individuals."

What about Besel's own philosophy on the quality of life? "I am concerned," she says, "that individuals should have the opportunity to choose the kind of life they want to live. The pressures of our society don't permit people to make many choices. Often, these people aren't even aware of being cheated of this freedom."

How is CNA related to the quality of life? What is the Association's role in enhancing the quality of life for its members and society at large? Besel is convinced that it is the responsibility of the national association to speak out on issues that have a direct bearing on quality of life — such as abortion, euthanasia, commitment to the aged, etc. She hopes that, by choosing this theme for the 1976 convention, CNA will be helping nurses to become more aware of the contribution they can make to society.



Marie-Andrée Bertrand



Glenna Rowsell



Lorine Besel

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Habitat

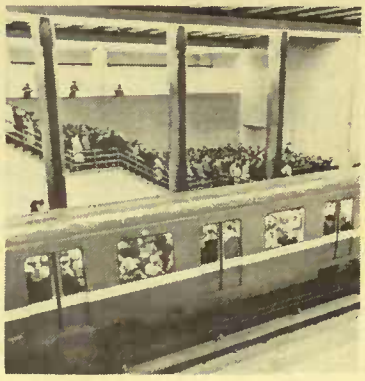
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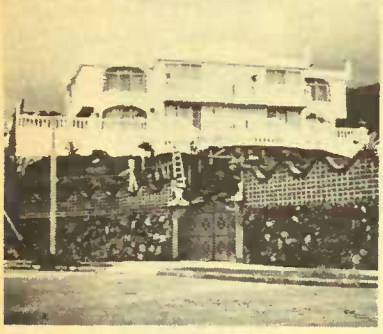
Claire Marcus

Canada may go down in history as the country where new solutions were developed for the world's growing human settlement problems. This is the goal of Habitat '76, the United Nations Conference on Human Settlements, being hosted by Canada in Vancouver, B.C., from May 31 to June 11. As providers of health care, nurses have a vested interest in the successful outcome of this conference.



























Photos courtesy of the Canadian Habitat Secretariat and International Development Research Centre.

abitat — a word that means 'he lives' in Latin — will ring together up to 5,000 delegates, visitors and journalists from 142 member countries of the United lations. Another 7,000 or more persons are xpected to attend the parallel Habitat Forum, a elated nongovernment conference and exposition. oth are an outgrowth of the United Nations' 1972 onference on Human Environment held in tockholm. Both have involved the years of reparation and strategy planning befitting a global roblem.

The Hon. Barney Danson, Minister of State for rban Affairs, has described Habitat as a process as uch as an event, and one that will profoundly affect ll Canadians.

"Like all countries," he said recently, "Canada is acing the challenge of accelerating change. Habitat epresents an opportunity for new initiative not only in neeting massive global requirements, but also in ddressing the needs of our own communities."

The problems are enormous, whether in ancouver or Calcutta. It has been estimated, for xample, that up to 7,000 people in Vancouver are iving in slums or deteriorating housing, with little hance of moving to a better place. In Calcutta, 79 ercent of families have to share living space. Except or Algeria, Libya and Iran, very few developing ountries have mounted large housing programs to neet the growing needs for shelter created by rapidly ncreasing urban populations. This lack of planning or settlements creates health problems. Less than alf of Brazil's municipalities, for example, have a atisfactory water supply system and only 34 percent ave a sewage system.

Solutions to these and related problems are the oal of Habitat, to ensure an improved quality of life or a global population that is expected to double by the end of this century. "Ideas come before bricks," said Enrique Peñalosa, the secretary-general of Habitat. "Delegations must go home from Vancouver with new ideas and practical plans."

New models and approaches to settlement problems are being tried out in many parts of the world and could be applied successfully elsewhere if they were more widely known. More than 250 audiovisual presentations of such solutions will be shown by participating countries at Habitat. The result will be a unique film library, later available to the nations of the world. Canada's contribution will be film or slide show presentations on four topics: Management of Urban Growth and Land Use; Design Innovations for Settlements in Cold Climates; Governing Human Settlements; and Community Rejuvenation.

Canada's preparation for Habitat included 14 symposia and 16 public meetings across the nation to enable groups and individuals to give their views and to hear those of specialists on settlement problems. The Canadian Nurses Association was represented at one of these planning meetings, held late in 1975, by the Executive Director, Helen K. Mussallem, and the President, Huguette Labelle. All provinces, through a Federal /Provincial Preparatory Committee, are involved in planning for Habitat.

On the international front, Canada has been working in close cooperation with the U.N. and, through it, with the countries participating in the conference. International groundwork included a four-day symposium at Dubrovnik, Yugoslavia in May 1975, attended by 30 of the world's best-known architects, planners, environmentalists and related experts; four regional meetings in Cairo, Teheran, Caracas and Geneva in which more than 100 countries took part; and the work of the 56-nation preparatory committee.

Plenary sessions of Habitat will be held in the Queen Elizabeth Theatre in downtown Vancouver, while the three committees that have the responsibility of developing recommendations for the plenary sessions will meet in nearby hotels. Technological installations provide for simultaneous translation into six languages, as well as for the showing of audiovisual presentations, and local, national and global news coverage.

Detailed strategy has been worked out for the provision of services such as accommodation, transportation, security, information, hospitality and health.

To meet the health needs of the 12,000 visitors expected in Vancouver, registered nurses will man four first aid rooms at downtown hotels during Habitat. In each station, the nurse on duty will be the primary contact and will provide the necessary care or direct the patient to a doctor in the Habitat medical office.

Should ambulance service or hospitalization be required, nurses will make the arrangements and advise the physician on duty at the medical office. If dental or optical services are required, an appointment will be made and the patient directed to the appropriate offices. Dental services will be provided by Health and Welfare Canada while optical services have been arranged with a local optician situated near the main conference hotels.

St. Paul's Hospital, in the downtown core of the city, will be the central receiving hospital for all conference attendees, and Habitat medical officers will have full admitting privileges there.

With the conference arrangements planned to the last detail, what will it all amount to? What difference will it make in Canada or other parts of the world if thousands of people talk about human settlement in Vancouver?

Yet how else can the world's settlement problems be tackled? Habitat organizers say that before the Stockholm conference, few governments gave priority to the environment; now virtually all do. Human settlement needs the same attention. There are skeptics in Canada, which is said to have an average of just over 0.7 persons per room, perhaps the lowest in the world. But despite this skepticism, Habitat will take place anyway, hopefully to develop a greater awareness of settlement problems, issues and new kinds of solutions.

The World



Man



Shelter



Habitat



12-HOUR PSYCHOTHERAPY

Twelve sessions of psychotherapy can be a useful treatment modality. The authors shed some light on the patient who chooses this form of treatment and on how the system works.

Susan Hill and Marcia Hoch

Susan Hill (B.N., University of Manitoba school of nursing) is primary psychiatric nurse therapist in the Outpatient Psychiatry Department, Health Sciences Centre, Winnipeg. Marcia Hoch (B.N., University of Manitoba school of nursing; M.S., Boston University school of nursing) was clinical specialist at the Centre when this article was written.

The authors worked together as primary therapists on an interdisciplinary team at the Outpatient Psychiatry Department, Health Sciences Centre, Winnipeg. As members of this team, they saw several cases where time-limited short-term psychotherapy was used to good advantage. They consider it an especially useful technique in helping persons deal with losses. They also found this approach a satisfying experience, since a specific goal is agreed upon and can be monitored for change during and on completion of the 12 sessions. The therapist can, therefore, readily evaluate her effectiveness.

Time-limited short-term psychotherapy, used as a treatment modality of choice rather than a treatment in crisis, is a relatively new concept in psychotherapy. Some major issues involved are: selecting and implementing the short-term therapy modality in light of indications and contraindications; factors to consider and even expect as therapy progresses; some implications for therapeutic intervention; and some relevant ideas related to transference and countertransference.

The comments that follow are based almost exclusively on the concept of short-term therapy developed by James Mann and, more specifically, on his contention that short-term treatment should be confined to the time limit of 12 sessions. Although at least one other therapist, Peter Sifneos, uses a time-limited treatment modality, he is not restricted to as definitive a time element as that advocated by Mann. Both writers, however, seem to agree that there must be a clearly identified focus for therapy before a time-limited modality is selected.

Limiting the number of therapy sessions to 12 is not in itself magical, but Mann suggests that this number is most effective, since it decreases ambiguity in psychotherapy by making the limitation of time constant in each case. Placing all patients within the same procedural framework makes it possible to assess the process and the outcome with some degree of consistency and reliability.*

* *James Mann, Time Limited Psychotherapy, Cambridge: Harvard University Press, 1973, p. 115.*

stribution of sessions can be flexible, but we efer the 12 sessions to take place each eek in 50-minute sessions. This seems to ovide consistency and render explicit the plications of time and its meaning to the ocess of separation and loss.

Major indications for selecting the hort-term treatment modality are: a goal that an be identified and, hopefully, reached; and e therapeutic alliance that can itself be used focus on one or two items in therapy, or on e precipitating event.

This form of therapy is perhaps most early indicated when issues involve dependence/dependence (patient has fficulty separating from family), healthy/low elf-esteem (certain behavior that renders atient vulnerable), and unresolved or delayed rief (loss of a meaningful relationship through eparation or death). Short-term therapy is ontraindicated during an acute schizophrenic eaction, a deep depression where the patient suicidal or too depressed to participate in herapy, a full-fledged manic reaction, or an rganic psychosis.

Process

A thorough history of each patient and an ccurate diagnosis are prerequisites in electing the short-term treatment modality. The goal is then clearly identified and agreed pon by the patient and the therapist, and a erbal contract is made.

The contract involves the *number* of essions (12), their *length* (50 minutes or one our), and their *arrangement* (12 one-hour essions per week; or 10 one-hour sessions er week, followed by a "free" month, after hich the remaining two sessions are held). The date of the last session is clearly set. The importance of attending each session is tressed — a missed appointment is counted s a session unless the patient's excuse is alid. As audio- or video-taping and supervision of each therapy session are of value, these matters should be incorporated nto the contract.

We have used the short-term contract primarily for dealing with issues of loss and delayed grief. The time-limited therapy has been useful for exploring feelings of loss and termination because the therapy itself implies an inevitable separation from the therapist.

Feelings of sadness and grief are reawakened in us with each termination. Thus, by helping the patient deal with his feelings about the termination of therapy, the therapist is indirectly helping him come to terms with the loss or losses for which he originally sought therapy. These are the major reasons for preferring a short-term treatment modality when grief work and loss are at issue.

In short-term therapy, the therapist usually becomes active and directive early in the initial interview, encouraging the patient to concentrate on the focus of therapy. This is important as both therapist and patient must consciously try to stay on the focus agreed on if the goal is to be reached. During the therapy sessions, concerns and situations not directly related to the mutual focus of treatment may be brought up by the patient. The therapist then asks the patient to reflect on the relationship between the issue that has arisen and the original focus. If no relationship can be discerned by either therapist or patient, the issue is discarded or used as a goal for a later therapy contract.

Problem solving

A general pattern can be expected to emerge over the 12-session period. During the first five sessions, the patient seems to improve markedly: anxiety and tension usually decrease and some of the presenting symptoms lessen. However, as therapy proceeds, the patient comes to realize that his problems are not all going to be solved, that one problem only is being worked on, and that even it may not be completely resolved. The therapist, too, may become discouraged as the patient realizes this but continues with the contract agreed upon.

What becomes more apparent in the seventh, eighth, and ninth sessions, is separation from the therapist. All the original symptoms may then reappear. The patient may become more melancholy and even show anger toward the therapist; he may arrive late for appointments, or express fear that 12 sessions "will just not be enough." These and other concerns need to be explored but, in general, it is wise to proceed with the agreed-upon number of sessions. Perhaps the most significant issue dealt with in short-term therapy is termination, with all its ramifications of separation, loss and grief work.

■ Antoinetta B.

Antoinetta a pretty, slim 22-year-old woman of Italian descent, came to the clinic with symptoms of depression: crying, inability to concentrate, feelings of low worth, and general misery.

Recently separated from her husband of three years, she had just come from another province and was staying with her married sister until she could find an apartment. Prior to leaving her husband, she learned of his involvement with another woman. Repeated phone calls have kept the situation stirred up, but Antoinetta is sure her marriage is at an end and seems obsessed with gaining some understanding of where she has gone wrong. She and her husband have agreed that she file for divorce.

One year prior to her marriage, Antoinetta's family had given her sister a lavish wedding. When her sister, six years her senior, left the household, her mother turned to the patient, her only other child, to fill the sister's place. The mother, apparently having entered her menopause at this time, became very demanding. Antoinetta admits this overwhelmed her at the time and she began to do things that were unacceptable to her parents, such as dating a non-Italian. The mother responded with much emotion, sometimes beating the patient and sometimes beating her own head against the wall. Antoinetta is concerned that she will be like her mother, and this frightens her.

The eventual outcome of the conflict between the patient and her mother was that the patient ran away to marry. She feels her mother drove her to it, otherwise she would never have married this man. Antoinetta's mother then disowned her and had no contact with her for more than a year. They have now been reconciled, but Antoinetta feels she cannot go home to her parents because of all that happened.

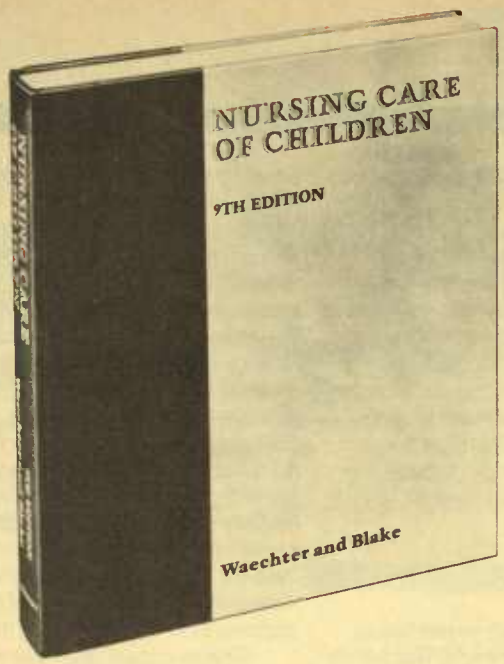
Antoinetta recalls an unhappy, lonely childhood. She was afraid her parents would die, had crying spells, bit her nails, and was shy. In spite of physical problems, which often kept her from school, she was on the honor roll in high school. She went on to junior college, where she met her husband. She continued to live at home until her marriage.

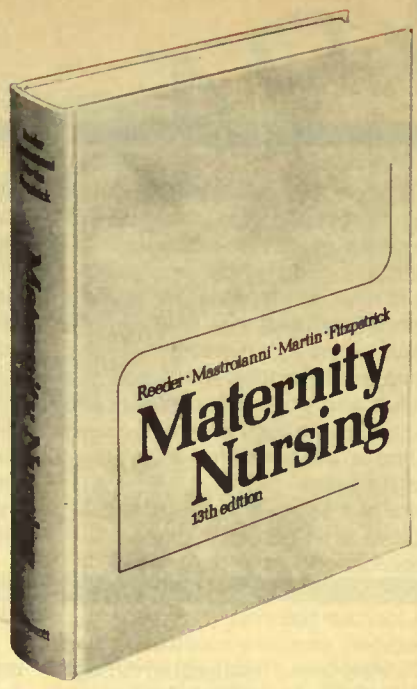
From this history, several concerns emerged as appropriate for treatment: a hostile-dependent relationship with her mother, problems with independence and getting started on her own, and depressive feelings about the marriage breakup. The diagnosis was reactive depression around the dissolution of marriage. Short-term treatment was agreed upon as a therapy modality with the focus being grieving over the loss of husband and marriage.

Following is a brief overview of the content of the 12 sessions and the major focus of each.

Session 1 Patient is in tears most of session. She talks of relationship with her mother. Recent difficulties began with separation from husband. Talks of guilt, and how the marriage dissolution was her responsibility.
Session 2 Talks of specific incidents in her marriage. Sad, crying. Relates how worthless she feels. Misses friends she left behind.
Session 3 Has begun to date a man but is afraid she will have the same relationship with him as with her husband. Is confused about the role of sex in her marriage.

→





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INTRODUCTORY

New

(1) NURSING CARE OF CHILDREN Ninth Edition

Eugenia H. Waechter, R.N., Ph.D., **Florence G. Blake,** R.N., M.A., and **Jane P. Lipp,** M.D.

Completely revised and expanded, this edition is without peer as an in-depth study of pediatric nursing. The text is organized by age groups, from infancy to adolescence, with emphasis on physical and psychosocial growth, development, and health care planning for each age. Major revisions reflect increased nursing responsibilities in assessment and management of the well child, children at risk, and the ill child. A completely new chapter on the role of the nurse in primary health care for infants and children includes specific measures in prevention and assessment of disease; interviewing; and anticipatory guidance with parents. An excellent presentation is provided on medical team management of disease and disorders in children. The latest information is included on management of specific problems—incidence and etiology, pathophysiology, clinical manifestations, complications, differential diagnosis, treatment and nursing care. Immunology and immunodeficiency diseases are covered in depth. 250 illustrations are new to this edition.

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New

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12-Hour

Session 4 Patient generally feels better. Thinks of moving from sister's home to her own apartment. Is planning around items she is to receive from her husband (kitchen utensils, furniture, and so on).
Session 5 Has found an apartment. Has been in touch with husband by phone. Is feeling sorry for him because he is now alone too. Looks forward to setting up her own place.
Session 6 Examining her feelings so closely makes her sad. States she feels uncomfortable with therapist. Disappointed that sister is not meeting her requests.
Session 7 Feels close to therapist. Not sure if 12 sessions will be enough. Frightened that she will have to return for more therapy.
Session 8 Sister and husband plan to move from the area because of job change — expresses anger and sadness. Angry with husband .
Session 9 Will miss therapist and wishes therapy could last longer. Crying about the breakup of her marriage. Ambivalent about it.
Session 10 Apartment shaping up. Has made a friend. Happy therapy is ending. More settled in her decision to get a divorce.
Session 11 Can hardly believe there is only one more session. Wonders if she can cope when therapy ends. Finds it hard to concentrate at times.
Session 12 Feels better, but sad at having to say good-bye.

The 12 sessions covered a wide range of topics but all were concerned with helping patient resolve her feelings about the loss of her husband and marriage. Short-term therapy seemed most appropriate for Antoinetta because the focus of therapy was clearly defined.

The first five or six sessions indicated that Antoinetta was making considerable progress. She was generally less depressed and more optimistic, and was involved in work and in setting up her own apartment. However, during sessions seven and eight, it became apparent that she had begun to feel the imminent termination with the therapist. The therapist interpreted Antoinetta's transference feelings of loss toward the therapist as reflecting her feelings about losing her husband. Sadness and anger were openly expressed and dealt with. The sessions ended on a positive note of growth and, in retrospect, short-term therapy had been effective.

Jane R.

Jane is a 24-year-old, single, grade three school teacher who lives alone in an apartment. She telephoned our clinic: "My boyfriend left me three months ago and I can't seem to get over it."

A thorough history elicited important information about the patient. Five years ago her best and closest woman friend was killed in a car accident. Four years ago her father left her mother for another woman, and they are now divorced. Three years ago, Jane's grandmother, to whom she had been close, died suddenly of a heart attack. A year ago, a previous boyfriend whom she had dated for three years left her. This time she took a serious overdose of sleeping medication. Jane spent a week in a psychiatric unit, her only involvement with psychiatry.

Jane is pleasant, cooperative, well-dressed and attractive. She showed no evidence of thought disorder in either content or process. She cried whenever she thought of her boyfriend and the details of their relationship.

Her diagnosis was reactive depression; and short-term treatment of 12 sessions was agreed upon, with the goal of helping Jane work through her grief over the loss of her boyfriend.

Following is a brief overview of the sessions and the main focus of each.

Session 1 Patient cries when thinking about boyfriend. Feels empty and lonely. Spends most of session in tears.
Session 2 More tears about boyfriend. Talks about losing her father, and how boyfriend resembles him.
Session 3 Feels therapist cares. Her problems worth the therapist's time. Is angry at father. Relates mother's situation with her own, as both men left for other women.
Session 4 Wants therapist to tell her what to talk about. Feels better. Afraid to get angry at people for fear of losing or hurting them.
Session 5 Boyfriend has come back to her. Worries about what therapist thinks of it. Wants to continue therapy. Changes goal. New goal is to work through feelings related to loss of therapist.
Session 6 Not feeling well: "the flu." Is angry at boyfriend and afraid to show it because he might leave her. Talks about termination of sessions. Cries over losing therapist. Feels alone.
Session 7 Sad it is the seventh session. All problems may not be solved: what if boyfriend leaves her after sessions end?
Session 8 Not feeling well. Talks more intensely about death of woman friend.
Session 9 Sad about imminent termination of therapy. Talks about angry episode with boyfriend. Tries to relate this to goal of separation from therapist.
Session 10 Finds it hard to believe sessions coming to an end. Expresses sadness rather than anger. Wonders if therapist will be available to her following termination.
Session 11 Expresses more difficulty over imminent termination. Several anxiety symptoms reappear. Attempts to relate curren feelings to her pattern of dealing with losses. Able to be more assertive in relationship with boyfriend.
Session 12 Doesn't feel she will say good-bye to therapist until therapy is over. Still worries over boyfriend leaving her. Still wondering if she will be able to contact therapist.

Jane is a young woman who has sufferec many significant losses she has been unable to resolve. The loss of her second boyfriend precipitated seeking help through our clinic. Based on the major issue of unresolved grief o loss, a goal was negotiated between the patient and the therapist, and time-limited short-term therapy was agreed upon.

During the first four sessions, Jane began to feel better and her symptoms disappeared. However, her boyfriend's return necessitatec changing the goal. A second goal related to loss (loss of the therapist) was agreed on, and the original contract of 12 sessions was retained. Jane was able to express her feelings about termination with the therapist. However, the goal was not resolved when the contract terminated.

Summary

The two cases cited illustrate how short-term therapy can be used to meet a patient's needs to deal with loss and grief.

Although the goals as set out in short-term therapy contracts are not always fully achieved, this treatment modality, as delineated by Mann, is valuable to psychiatry. Short-term therapy is not only a sound therapeutic intervention, but also a means of bringing psychiatric health care to a greater segment of the population.

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WHY?

The author's name is known to The Canadian Nurse *but is being withheld.*

Several months ago my husband died and I am still bitter. My bitterness stems, not from his death, but from the attitude of the people who work in the hospital where he died. Hospitals see death as the end of their responsibility, but for the survivors it is the beginning of a totally new way of life. As a nurse, I have always believed that the family of a person who dies in hospital should be treated as well, after the event, as before, but experience has taught me that this is not always the case.

My husband had problems with his heart for some time. Eventually, our family doctor referred him to a cardiologist in a city 800 miles from here. He was hospitalized there and we kept in touch by phone. When heart surgery was planned, we agreed that I should stay home with the children until he was convalescent.

On the Sunday night before his operation was scheduled, he died. It was then the series of events began that shattered the ideals I had come to cherish in more than 25 years of nursing.

The doctor phoned early on Monday morning to tell me what had happened. I agreed to an autopsy and remembered to tell him that my husband had an eye bank donor card with him. He asked me to send a telegram to the hospital admission office giving them this information. I did so immediately.

At noon that day, my husband's cousin, his only relative in the city, phoned to enquire about his operation. I had not yet contacted her since she works during the day and I didn't know where to reach her. She was told curtly to get in touch with either me or our family doctor.

At supper-time I phoned to give her the news myself and ask her to find an undertaker. When she phoned the hospital again she met the same response. She persuaded them she knew he was dead and was told the body would be released early the next morning.

On Tuesday, the undertaker was refused the remains because "we don't have the telegram." My own clergyman and another in the city were asked to help. They got the same story. I phoned the admission office. The response was: "Maybe I'll leave a note for the day staff," "Maybe I'd better contact the doctor" and "We can't release the body on your say-so." Naturally, I did not react calmly and my replies were not as coherent as they might have been. When I hung up, however, I believed that the action I demanded would be carried out immediately. I phoned the undertaker and gave him that information. At home we proceeded to plan the funeral and notify people living several hundred miles away of the date and time.

When the undertaker phoned on Wednesday, it was to let me know, as tactfully as he could, that he had had difficulty obtaining the body, and that, since no doctor was available, he had had to ask the coroner to sign the necessary papers. Because of the delay, he wasn't certain whether the cremation would be completed in time for the plane! This meant changing the day of the funeral from Thursday to Friday and more long distance calls. For those taking time off from work to do my husband honor, this change was most disconcerting.

Nor was this the end of the matter. In my first phone call to the admission office I had asked that my husband's cousin be given all of his personal effects. She made eight trips to the hospital before it was convenient for anyone to accommodate her! Even then, she was given his wallet with his credit cards but not the thirty-seven dollars he had deposited in the office. Finally, three months after my husband died, I learned that the autopsy I had agreed to, had not been done. I had agreed, not to help medical science, as we are taught to say, but simply because I wanted to know why he died at that time. Now I never will.

Two weeks after these events, I wrote a letter of complaint to the hospital administrator. A month later, another hospital official sent me a letter of apology. *This was the first time any member of the hospital staff contacted me.* He reminded me that they were short-staffed and busy. He told me how dreadful it would have been if someone besides myself were told that my husband was dead. I couldn't help but remember that, when I learned of his death the first thing I did was to start notifying family and friends. With a broken-hearted ten-year-old son in my arms, what would I have given to have someone say "Yes, I know," instead of "Why, what happened?"

As for the telegram, a tracer proved that it had been phoned to the hospital within an hour of my phoning it in to our local office. Apparently a copy was then mailed to the hospital rather than being delivered in person. What legal status does a telegram have? Anyone can send one and sign any name he pleases. Surely, it would be possible to tape-record permission for an autopsy and other similar consents. The human voice is as distinctive as fingerprints.

Legal counsel advises me that not carrying out the wishes of the next of kin amounts to negligence, but I have no interest in lawsuits. The past cannot be undone. My concern now is to try to prevent other people in similar situations from being subjected to the

emotional stress I endured. Why couldn't some person have been designated to contact me an hour or so after the doctor told me of my husband's death and tape-record the conversation? That person could have assisted me in locating an undertaker and found out what to do with my husband's personal effects. He or she could have taken phone calls, given out the information that he was indeed dead and arranged a suitable time for his effects to be picked up. The situation could have been handled without the mental anguish that resulted from the fact that, when my husband died, no one in that hospital accepted the responsibility of meeting the needs of his family in their time of bereavement.

I am told that some of the policies in this particular hospital have been changed since this incident. What happens when someone in your hospital dies?

When *The Canadian Nurse* approached the hospital where this incident occurred, a spokesman gave his interpretation of the "administrative difficulties" encountered by the author of "Why?" His answers to some of the questions she raised are as follows:

Q. Why did the hospital not phone me?
A. Our hospital insists that it is the duty of the attending physician to notify the next of kin when a patient dies. This is a traumatic occasion requiring an expert handling of the communication, understanding and often explanation. The patient made himself the client of the doctor for the management of his health care. It is only right and proper that the doctor communicate with the family when death occurs rather than leave it to a nurse or ward clerk who may or may not communicate in the appropriate manner.

Q. Why could a relative not be told of a person's death — particularly when it concerns an out-of-towner?
A. The inability of your husband's relatives to obtain information by phone about his death should be seen in light of the policies laid down for our staff in that department. This type of information can only be released by relatives (present) or the attending physician to avoid the next of kin learning about the death in a second-hand manner.

Q. What protection does the patient or his family have from a telegram that passes through many hands, can be garbled, or as in this case ignored?
A. We apologize for the tragic delay in communicating your consent for autopsy to our pathologist. However, these are very important consents for which we have developed stringent policies. You can't imagine what the reaction would be of relatives if an autopsy was done without their consent. We must have in our possession the official written document, i.e., the telegram, before we can proceed. Although the contents of the telegram were phoned to the hospital, the telegram company put the telegram in the mail rather than delivering it by hand the same day as has been the practice. Therefore, it took two days before the telegram reached the hospital and the clerk in the Admitting Department was correct in saying the telegram had not arrived. I can assure you you that we have not had a similar incident in at least the last ten years. We regret very much that it happened in your case.

Q. Are patients' wallets checked when they die, for such things as organ donor cards?
A. The normal procedure in this hospital is to encourage all patients to leave valuables at home. Valuables brought to hospital are placed in safekeeping and released only to the patient on discharge or to the next of kin. Wallets are only opened for authorization permits when the patient or his relatives have indicated to us that he wishes to be a donor. When the patient has been an accident victim the police go through his wallet for identification and find the donor authorization card.

No changes in our polices have resulted from this incident but two areas of existing policy have been reinforced:

Although our policy demands written consent for autopsy, we do state that when consent must be obtained from remote areas, we will proceed with autopsy on the verbal authorization of the next of kin, witnessed by two members of our staff. The staff member on duty in the Admitting Department was a summer relief person and she went "by the book" and failed to communicate the verbal authorization. For this we offer our apologies.

Our policy in respect to phone communications is that courtesy and consideration must be extended at all times. This incident was forcefully brought home to our staff as an example of communications which obviously fell short of the recipient's expectations.

If there are lessons to be learned from the unfortunate experience, feel free to publish anything in this letter that you deem of value.

The Executive Director, ... Hospital.

LIVING WITH CYSTIC HYGROMA

Every mother must from time-to-time cope with illness in her child — part of her is always a nurse. For this mother of a child with special health problems, nursing is a 24-hour a day challenge. In this personal account she describes some of the feelings of parents who have to cope with this type of nursing care.

Catherine Brown



A few weeks ago, I was talking with other mothers about an endlessly absorbing topic: our children. We were discussing our fears about illness. One woman said, "I know it's just a superstition, but I put an evil eye in my baby's bed, just to help ward off sickness." Another confessed, "Sometimes I think of all the horrible accidents that might happen to my baby, and I just shudder!" "Yes," everyone agreed, "but aren't you glad those terrible things don't really happen?"

I sat silent among them thinking, "I'm different because those unthinkable things have already happened to my child, and I know that no evil eye, nor all my wishes, could have prevented them."

My baby was born with cystic hygroma, an unusual condition in which his face is filled with cysts that swell and go down periodically, and are easily infected, until he is at least five or six years old. This condition also affects the tongue, causing it to swell, bleed, and, if badly enough infected, to cut off his breathing, so that a tracheotomy becomes necessary.

In the city where I live, specialists in this field favor waiting the condition out, rather than surgically removing the cysts. For several reasons, they feel that surgery is too traumatic for a young child, as well as ineffective in removing the cysts. The only treatment they prescribe is penicillin, when absolutely necessary, and waiting for five to six years until the condition becomes minimal.

These are the technical details. They do not begin to express the agony a mother feels when her child's face begins to swell, her embarrassment for him when other children laugh and point nor her horror when he stops



Clinical Data

Cystic hygroma is a rare, endothelium-lined, cystic lesion of lymphatic origin which usually occurs around the neck and is encountered most frequently in infancy and childhood. It affects bot sexes equally and is discovered at birth in 50 - 65 percent of cases About 80 - 90 percent of cystic hygromas are detected before the en of the second year of life; in rare cases, however, it has appeared in the teens.

Although the disease was reported as early as 1828, it was fir named and clinically described by Adolph Wernher in 1843. Man theories were advanced about its cause and relationship with th lymphatic system, but today it is generally thought that in the fetus during the formation of the peripheral lymphatic system, a pinchin off or sequestration of tissue of one of the endothelial sprouts o outbuddings that extend from the primitive sacs of the lymphatic system, gives rise to an endothelium-lined lesion called a hygroma The lesions of cystic hygroma can vary from 1 mm to 5 cm in diameter but have in common a potentiality for increasing in size to an almost unlimited extent, and a tendency to penetrate and destro anatomic structures.

The accepted explanation for their growth and propagation wa advanced by Goetsch in 1938. He concluded that endothelial fibrilla membranes sprout from the walls of the cysts, penetrate into surrounding normal tissues, then canalize and produce cysts fille with secretions from the fibrillae. The pressure from the larger cys may force the tumor to spread in the lines of least resistance, i.e. int the planes or spaces between large muscles or vessels.

Thus, the mass called cystic hygroma is composed of a thin-walled, endothelium-lined cyst (or cysts) which is filled by a

breathing. Not to mention the endless trips to various doctors and her frustration as a mother in the face of their cool authority.

I was wide awake when Stephen was born — glad to have gone through labor so easily and proud to have a healthy boy. My obstetrician said his face looked a bit "puffy" on one side, but dismissed it as a swollen gland and told me my pediatrician would check it out later.

That night, after my husband and I had cuddled our new son adoringly, puffy face and all, my pediatrician came in to speak to me. He is a kind, sensitive man, but his words took my breath away. "I want to talk about Stephen," he said. "I've just checked him. He doesn't show signs of mongolism, but he has a tumor that must be examined, so I'm sending him over to the children's hospital tonight to be analyzed. Perhaps your husband could take him over."

I was so shocked at the words, "mongolism," "tumor," and "another hospital," that I could only nod my head in amazement.

After he left, I sobbed in despair. Though Stephen was returned the next day, he was now pronounced "abnormal" with a "special condition," that might or might not go away. My first son had always been so healthy, that I took good health for granted. Matthew always slept through the night and the worst thing he ever had was a diaper rash. How could my children be less than perfect?

Stephen's problem became evident during my stay in hospital. His enlarged tongue made it a struggle for him to breast-feed. What had been so natural for my first son was torture for Stephen, so I bottle-fed him instead.

I wanted to deny that he had a problem, but from day to day, I could see that he did. It took longer for his umbilical cord to heal, his circumcision hurt and bled more and he slept less soundly than Matthew. As I came to realize these differences, I searched within myself for the cause of his problem. What had I done wrong? Had I eaten the wrong foods while pregnant? Worked too hard? Been too upset? I had had spotting in the sixth month of pregnancy. Had this harmed Stephen? Had the delivery been wrong? Was it related to my father's illness? Though doctors assured me that none of these factors made any difference, it took me almost two years to overcome these feelings of guilt.

The first few months were hectic—managing two young children and the house as well as being a companion to my husband. We were still on a survival level day-to-day coping. As Stephen got older, h developed a very engaging personality — warm smile, a cuddly, puppy-dog friendliness an intriguing way of playing with his fingers — source of fascination and jealousy to his brother. We loved him passionately.

Also, as Stephen got older, other aspec of his illness manifested themselves — endless colds, weak stomach, series upon series of antibiotics. Then in the spring, ou babysitter left the gate open at the top of th stairs. Stephen, in his playchair, fell down th stairs, knocked a tooth out, pushed others in his gums and bit his tongue the whole way through. I rushed home from work, took on look at what was left of his mouth and race him to the doctor, who sent us to the hospita

We were all crying. All the recriminatio my husband and I could make about the gat the babysitter, ourselves, made no differenc The fall touched off a mouth infection that p Stephen in hospital for nearly a week. He wa in an oxygen tent and was given penicillin intravenously. I suppose I should have bee thankful that he was less badly off than the

clear, colorless fluid. The cysts may contain lymph nodules, muscle fibers, thrombosed blood vessels, or bits of fascia, depending on the type of tissue entrapped by the tumor.

Outwardly, cystic hygromas are characterized by their soft, flaccid, "doughy" consistency and by their thin walls and translucent appearance, particularly evident if they are large in size.

The most common symptom is a soft mass in the posterior triangle of the neck. It is not attached to the skin but fixed to the deep tissues. Patients rarely experience pain or local discomfort and, if the lesions are small, medical advice is often not sought for many months. In some cases, a mild trauma or secondary infection is followed by rapid growth of the cyst and it is this series of events that prompts a visit to the doctor. Some hygromas lie dormant or increase in size slowly, some grow rapidly and then appear to shrink. In some cases, respiratory obstruction occurs.

Various treatments have been attempted with cystic hygroma, some more successful than others. Many doctors prefer surgical excision, but the extent of the tumor cannot always be anticipated and, if the cyst involves vital nerves and vessels, portions of the tumor must be left behind. In this case, there is a risk of recurrence, though this usually occurs within one year.

Some doctors prefer to wait indefinitely, administering antibiotics when necessary, because of the tendency of a hygroma to undergo spontaneous regression. The danger with this approach is the high risk of spontaneous infection which may occur with even a mild respiratory inflammation and, if severe, may threaten the patient's life.

Other treatment measures that have been tried include repeated aspirations, irradiation and injection of sclerosing chemicals. None of these, however, has proven satisfactory.



other children in the burn ward. Some had such hopeless, woebegone faces. All I wanted was to get him released as soon as possible.

When Stephen came home, we felt that he would be all right again now that the warm weather was coming. We celebrated his first birthday in May, joyously hoping our troubles were over. A week later, we found him face down in the grass, turning blue. He had stopped breathing. I whacked him on the back, pulled his tongue down and gave him mouth-to-mouth resuscitation.

Since, then, we have become more resigned. We treasure the times when Stephen is well, and brace ourselves for the difficult times when he is sick. Of course, I try every conceivable thing to help him — elevating his mattress, putting a humidifier in his room, feeding him vitamin C, keeping him on antibiotics for the winter, seeking out another mother whose child also has cystic hygroma to pool our experiences.

Always in the back of my mind is the hope that someone will find a solution, a cure, but gradually that hope is coming up against the stark reality of waiting out the next few years.

Every mother must cope with illness in her children — part of her must always be a nurse. Stephen's condition could be much worse but because my other child is so exceptionally healthy, I find it hard to assume this nursing role. Stephen usually needs 24-hour-a-day care. Everyone in the family has had to adjust to his illness. The tension and sadness we sometimes feel about Stephen is naturally communicated to Matthew. We want him to have a normal life but he is beginning to ask why Stephen needs so much medicine, why he wakes up every night, why his face goes up and down. Because my husband works full time, I am usually the mediator between our family and the doctors and have to relay all the messages. Sometimes my husband takes out his frustration about Stephen on me and often I need extra support from my husband.

Stephen faces the biggest adjustment. At 18 months, he is active, contented, self-confident, full of enthusiasm and spirit. But soon he will read the expressions on people's faces, feel hurt when they stare at him, realize that he is different.

We can only cope day by day, working out solutions to problems as they arise and enjoying our two children as they are, while waiting for that elusive, perhaps nonexistent, time when Stephen will become, magically, normal.

Catherine Brown, in addition to being the mother of Matthew (four) and Stephen (almost two), teaches family life education at Humber Community College in Toronto and is an active member of Aid to New Mothers, *a support group for mothers during the postpartum period.*

This group grew out of a Women's Health Group and has evolved into a city-wide organization that helps to bring together the work of public health nurses, hospitals and Children's Aid workers.

She and her husband, came to Canada seven years ago as graduate students in English.

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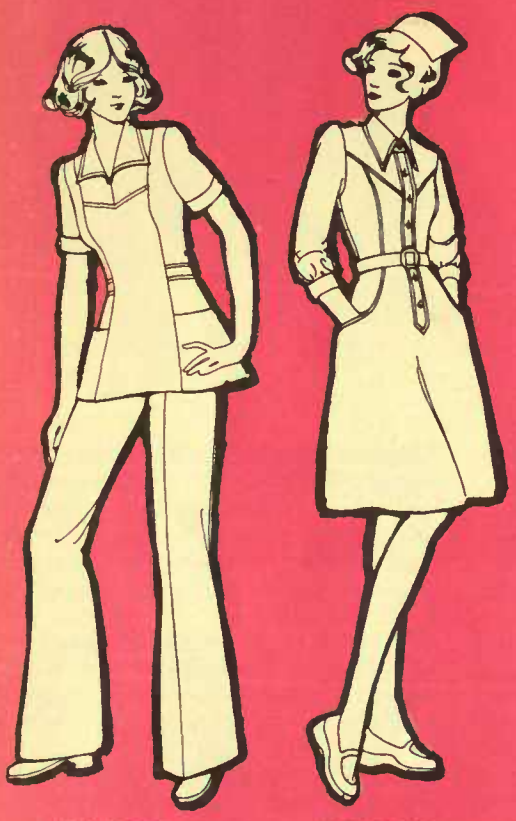
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Names and Faces



The Ontario Occupational Health Nurses' Association elected for the 1976-1978 term of office the following: president, **Dorothy Schwab,** Reg. N., of St. Catharines; 1st vice-president **Joan Subasic,** Reg. N., P.H.N., of Toronto; 2nd vice-president, **Grace Blackwell,** Reg. N., of London; secretary, **Gale Pearson,** Reg. N., B.A., of Guelph, and treasurer, **Sylvia Matchett,** Reg. N., P.H.N., of Mississauga.

This organization, for registered nurses employed in the field of occupational health, is dedicated to the improvement of health services available to workers throughout Ontario via the promotion of educational opportunities for the nurses involved.

Gwynneth Paterson (R.N., Queen Elizabeth Hospital, Montreal) has been appointed Assistant Executive Director of Patient Services, at Medicine Hat General Hospital.

Paterson has nursed chiefly in Ontario and Quebec, her latest position being Director of Nursing of the Montreal Convalescent Centre. She brings to Medicine Hat General many innovative ideas regarding nursing. She feels that nursing personnel must begin to work with rather than for other health personnel. In her judgment, Medicine Hat General is ready for change, and the staff involved have the potential. She wishes to develop nursing programs for patient care, rather than rely totally on existing doctors' programs for patient care.

Paterson is at present working toward a master of science degree in administration from McGill University.

Peggy Overton (B.Sc.N., M.H.S.A., University of Alberta) has been appointed assistant professor, full-time research, in the division of health services administration at the University of Alberta. Her responsibilities center upon pure and applied research with reference to effective and efficient health delivery especially, but not exclusively, related to nursing, and involve participation to the multidisciplinary team research of the Division.



Overton was a recipient of a National Health Research and Development research training fellowship. She was formerly a surgical supervisor and nursing project coordinator at the University of Alberta Hospital, Edmonton.

Catherine MacQuinn, (R.N., Highland View Hospital school of nursing, Amherst) a public health nurse who works among the Indian people in Cape Breton, has been presented with a 25-year pin and certificate from the Medical Services Branch, Health and Welfare Canada.

For several years, MacQuinn lived on the Eskasoni Indian Reserve where, early in her stay, she often delivered babies by the light of a kerosene lamp. Over the years she has seen the self-development of the Cape Breton native peoples; their changing attitude toward education, their improved health and housing.

Jacqueline Sue Chapman, R.N., Ph. D., is principal investigator of a federally funded study: "Effect of Hospital and Home Planned Stimulation on Development of Short Gestation Infants," to evaluate the relative efficacy of selected interventions in the nursery previously found to facilitate the development of short gestation infants. The longitudinal aspect of the study is to develop a program (in consultation with Institutes of Child Development on this continent) to maximize the potential of the child who may be developmentally and/or economically disadvantaged.

Pamela E. Poole (R.N., Queen Elizabeth Hospital school of nursing, Montreal; B.N., McGill University; B.J., Carleton University, Ottawa; M.S., University of California, Los Angeles) has been appointed chief of the information and evaluation division, Research Programs Directorate, Health and Welfare Canada. She is responsible for the planning, development, and direction of a program of completed research funded under the Natonal Health Research and Development Program. She is also engaged in planning, development and direction of a research information program that deals with dissemination of research findings and the provision of statistics and other data on health care research.

Poole joined Health and Welfare Canada in 1965. She is a former assistant editor of *The Canadian Nurse.*

Anne S. Gribben, Chief Executive Officer of the Ontario Nurses' Association, was appointed a part-time member of the Ontario Labour Relations Board, an honor that gives her official recognition as a leading member of the labor relations community. It is the first appointment to the board of a woman, and the first time a union as young as ONA has received this type of official recognition.

Gribben was formerly director of employment relations of the RNAO.



Dorothy Fulford (R.N., Winnipeg General Hospital school of nursing; P.H.Dipl., University of British Columbia; B.A., Carleton University, Ottawa) has been appointed employment relations officer with the Ontario Nurses' Association, Ottawa office. She brings to her position a rich experience in public health nursing, having been with the Victorian Order of Nurses in Winnipeg, Toronto, and Burnaby; the Toronto Department of Health; the Ottawa Board of Education; and the Ottawa-Carleton Regional Health Unit. She also has a background of collective bargaining, having been on the negotiating committee for the Institute of Professional Personnel of Ottawa-Carleton

Barbara McWilliams (R.N., St. Paul's School of Nursing, Vancouver; B.Sc.N., University of British Columbia) has been appointed assistant director of education services with the Registered Nurses Association of British Columbia. She will provide counseling services to members and others and participate in various committee and departmental projects. McWilliams was formerly a public health nurse in Burnaby and has worked as an occupational health nurse, in the office of a family practitioner, and as a staff nurse in intensive care.

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What's New



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For information write: American Hospital Supply, 1076 Lakeshore Rd. E., Mississauga, Ontario L5E 3B6.

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Orthopedic Equipment Company's brochure in color describing the new OEC hinged Stanmore total knee replacement.

This implant utilizes an ultra-high molecular weight polyethylene bushing for interphasing between the femoral and tibial components. The flexibility and weight-bearing joint stability of the bushing renders the Stanmore knee joint particularly suitable for total knee replacement when rheumatoid/osteoarthritic knees have virtually no ligamentous stability.

The brochure is available from: Orthopedic Equipment Company, 1011 Haultain Court, Mississauga, Ontario L4W 1W1.

Thomas Traction Kits

Thomas traction kits from Orthopedic Equipment Company provide for quick, emergency Thomas leg splinting. The deluxe kit (No. 3034-10) contains two sizes of Thomas leg splints, two sets of splint straps, two heel rests, two foam-padded ankle hitches and a Redi-Trac traction device — all arranged for quick access in a sturdy case that is carried directly to the accident victim. The foam-padded, vinyl-covered carrying case can also be used as an insulated emergency blanket when laid out flat, with all equipment removed.

Two smaller kits are also available: Kit No. 3040-04 contains one large Thomas leg splint, plus accessories; Kit No. 3040-02 contains one small Thomas leg splint, plus accessories.

For further information write: Orthopedic Equipment Company, 1011 Haultain Court, Mississauga, Ontario, L4W 1W1.



Stylish Safety Vests

New color print vests to help prevent patients from falling out of bed or sliding forward in wheelchairs, have been designed by the J.T. Posey Company of Pasadena.

These vests are in three styles: the Poncho Vest for gentle support; the Comfort Vest, a difficult to remove model, and the standard safety vest. Each style comes in red, blue, yellow, and pink and is available in small, medium and large sizes.

Posey products are available in Canada from Enns and Gilmore Ltd., 2276 Dixie Road, Mississauga, Ontario L4Y 1Z5.

Washing Equipment Catalog

The operational and design features of AMSCO washing equipment are highlighted in a new eight-page catalog. Described are 3 different utensil washers, a portable flask washer, a hospital cart washer and a glassware washer and dryer. Productivity of the units and the resultant benefits to the user are also detailed for each piece of equipment.

For a copy of AMSCO Catalog IC-615 on washing equipment write: AMSCO/American Sterilizer Company, Attention: Market Communications Department, 2425 West 23rd Street, Erie, Pennsylvania 16512.

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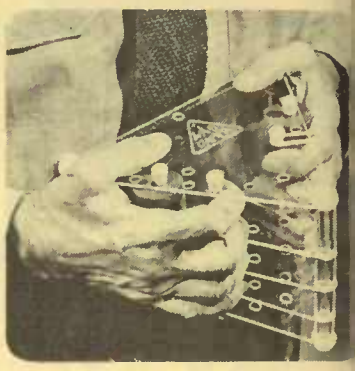
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For information, write: Product Manager — Canada, Bilsom International AB, c/o Swedish Trade Commissioner, 920 Yonge Street, Suite 820, Toronto, Ontario, M4W 3C7.



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For further information, contact Orthopedic Equipment Company, 1011 Haultain Court, Mississauga, Ontario, L4W 1W1.

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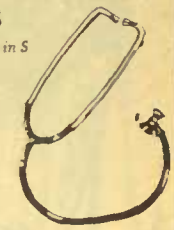


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Research

Reid, Una Viviene. A Survey of Resources for Continuing Education in Nursing in Northeastern Ontario. Vancouver, B.C., 1975. Thesis (M.S.N.) University of British Columbia.

This descriptive study focuses on resources for continuing education in nursing in Northeastern Ontario and is concerned with the establishment of a continuing education program for nurses in that area within the framework of a regional plan.

An extensive literature review supports the approach of establishing such a program on a regional basis.

Available resources for a program of continuing education in nursing in Northeastern Ontario were identified using the descriptive survey research method.

Based on the 72 percent response, the major finding of the survey is that on a regional basis human and physical resources and educational materials are inadequate in terms of number of institutions or agencies possessing such resources. An overall assessment of the adequacy of the resources indicated disparity between districts in all currently available resources. Within districts availability of resources also varies. Some districts are without certain categories of resources.

The survey also reveals that there is a high level of interest (91 percent of respondents) in continuing education in nursing within the region. An overall plan of continuing education in nursing must pay special attention to filling these inadequacies in order to ensure an effective program.

Rakoczy, Mary, The thoughts and feelings of patients in the waiting period prior to cardiac surgery — Montreal, Que. 1975. Study (M.Sc. (Applied) McGill University).

This study examined the thoughts and feelings of patients in the waiting period prior to cardiac surgery. The waiting period was defined as the three days (72hours) prior to surgery.

The methodological approach to the study was grounded theory, using unstructured interviews with patients on a cardiovascular surgical ward.

The research questions that directed the study were:
1. What is the patient's attitude toward cardiac surgery?
2. What kinds of thoughts and feelings emerge in the waiting period prior to cardiac surgery?
3. Are there identifiable patterns of thoughts and feelings at different points in time?
4. What meaning do these thoughts and feelings have for nursing care?

The types of thoughts and feelings revealed by patients tended to occur in particular groupings in an identifiable time period and sequence. A composite profile of these clusters and their sequence of occurrence formed phases of the waiting period and the conceptual model for data analysis. Most patients made statements that reflected a passage through each phase. The phases labelled in order of their occurrence, were: Confrontation, Self-Reflection, Resolution, and The Countdown. Findings include:
1. In the initial "confrontation" period, patients (a) were often in a state of shock, or disbelief; (b) felt they had no alternative but to have surgery, regardless of the duration of symptoms; (c) expressed concerns centered around feelings of helplessness and fear of impairment; (d) generally had little knowledge about the impending surgery and did not request information; (e) talked about their families and stated they were interested in having them present to talk with; and (f) referred to the importance of seeing or hearing about a successful patient.
2. In the "self-reflection" period patients indulged in apparent self-pity or grieving, suffered feelings of guilt, and mourned their loss of control.
3. The "resolution" period was characterized by expressions of hope of recovery, rebuilding of confidence and self-esteem, and the final decision to undergo surgery.
4. In "the countdown," patients were often "talked out" and were most interested in visible signs that indeed "the countdown" had begun e.g. the presence of the family was sufficient in itself.
5. Generally, patients who progressed through all the phases or from "confrontation" to "self-reflection" had good outcomes. Those who went directly from "confrontation" to "the countdown" had poor outcomes.
6. An overall finding, which initially prompted this study, was that these patients were often alone, and that there appeared to be limited nurse-patient interaction.

Pope, Marion. *Canadian health services used by Korean immigrants and their perceptions of the helpfulness of those services.* Toronto, Ont. 1975. Thesis (M.Sc.N.) U. of Toronto.

The study was undertaken to describe the Canadian health services used by Korean immigrants, the reasons for which they used the services, and their perceptions of the helpfulness of those services. The purpose was to contribute to the understanding of how Korean immigrants try to meet their health needs through the health care services in the community. It was hoped this understanding would help health professionals work more effectively with Korean immigrants.

The investigator used a family interview schedule in Korean in the homes of 30 respondents drawn proportionately by lot from 90 heads of families registered in 2 districts, one suburban and one inner city. Responses to non-structured questions, designed to elicit free expression of opinions, were organized into classification schemes of reasons for use and perceptions of helpfulness.

The group of 106 persons used a narrow range of health services with which they had been familiar in Korea. Over 50 percent of all services were used for acute physical illness. Official government services were used for health supervision, but almost always on the initiative of the public health nurse. The group lacked information about community health services that had not been available in Korea. The most frequently cited reason for helpfulness was effective treatment.

Services were not helpful or nc used because of lack of informatior and language problems, and becaus of inconvenience, mostly conflict wit the working hours of the head of th family.

Implications from the findings include the need to encourage initiative by both members of the Korean community and health professionals in providing informatio interpreting and adapting services, and in using Korean immigrant representatives as resource person

Anderson, Joan Madge. *The concerns and coping behavior of the single mother with a chil aged six months to eight years* Vancouver, B.C. 1973. Thesis (M.Sc.N.). University of British Columbia.

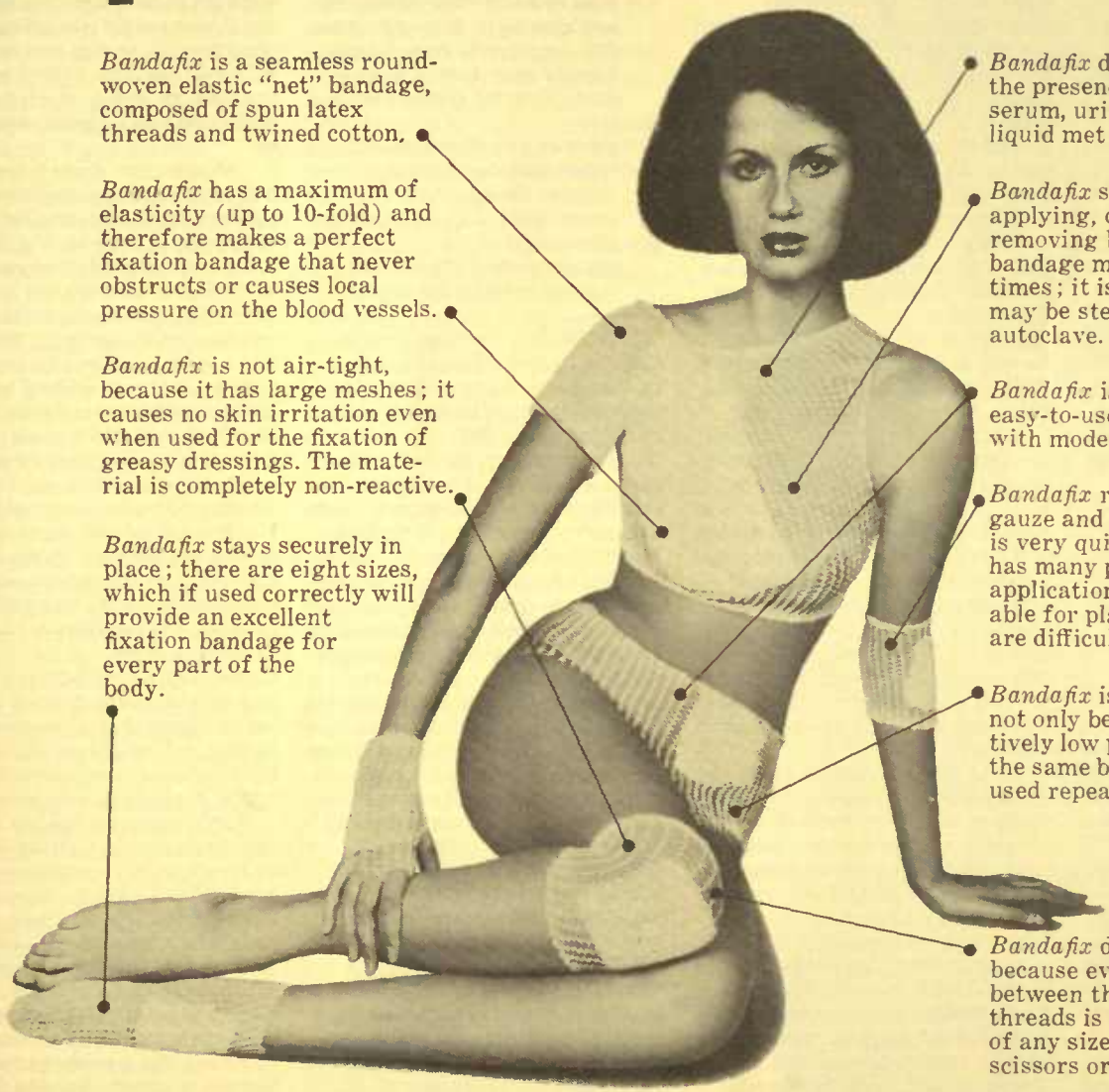
This study was designed to elic information about the concerns anc coping behaviors of the unmarried mother.

Twenty unmarried mothers we interviewed in their homes, using a semi-structured questionnaire. The ranged in age from 20 to 36 years, an had from grade 7 to 12 education. Fiv were employed full time, 4 were ful time students, 14 received social assistance, and one, a full time student, supported herself and her child on a student loan.

Mothers' concerns were relate to finances, child care facilities, housing, job training, and adequate information from agencies concernir services available to mothers on soci assistance.

Of the mothers (45%) whose scores on an emotional health stati scale indicated some emotional impairment, many also perceived themselves as having a high numb of socioeconomic problems. Forty-seven percent of the mothers who felt a need for consultation abou a specific concern sought profession help. However, many preferred to ta with friends and/or relatives about their concerns. Only among 15 percent of the mothers did the child father provide any emotional suppo

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Books

Contemporary Community Nursing edited by Barbara Walton Spradley. 467 pages. Boston, Little, Brown and Co., 1975.
Reviewed by Patricia E. Ridge, former instructor, Dept. of Allied Health, Selkirk College, Castlegar, B.C.

The editor has skillfully selected articles by well-known authors that are relevant, realistic, stimulating, and readable. Most of the articles were published orginally during the 1970's. Together they form a comprehensive overview of community health nursing. The editor has included every basic and important aspect of the field today, in an attempt to present a framework that is easy to understand.

The articles are organized into eight chapters. Each article seems a logical follow-up of the one preceding it, and many examples of actual situations are included. Some of the many examples are American experiences, but are applicable to other situations.

The book begins by defining community nursing and its goals in the present day. The community nurse is defined as a "generalized specialist." She has the responsibility to plan and implement health care and is often the key person in the process. The humanistic approach to community nursing is a constant theme throughout the book. The editor states that community nursing must change as society and its demands for health care change.

The last part of the book deals with the nurses need to know the community, to be able to assess its needs, and to participate in planning for the betterment of its level of health. Donald C. Klein's conceptual framework for understanding a community is presented and Madeleine M. Leininger's model of the open health care system, that provides readily accessible personalized care, is described.

The many and various roles of the community nurse are presented in a thorough and exciting manner. Sandra Henry Kosik's comments on "Patient Advocacy" are interesting and Leonard Stein talks about the doctor-nurse game, vestiges of which are still present.

One chapter contains articles that describe the use of the nursing process in community health nursing and how members of a family or a community can be involved in it. Application of Dr. Lawrence Weed's problem-oriented medical record system to community health is described and Marlene Mayer offers some assessment criteria for more systematic evaluation of nursing care. Different views on the value of the nursing audit, to evaluate the quality of care in a community by M. Phaneuf and A. Donabedian, are included.

Spradley has devoted a chapter to stress the importance of the ability of the community health nurse to communicate skillfully with all kinds of people. One study presented reveals that nurses tend to be nurse-focused not patient-focused in interviews during home visits. An essential element in communication, empathy, is discussed by Beatrice J. Kalisek. The concept of contracting with families to assist them in using their own strengths in dealing with health is described.

The editor presents material that the nurse should understand about the family in community nursing: the influence of its members on health and illness; the effect on family roles when a member is a patient; and how the nurse can stimulate a family to help itself. There is a good article by Ruth F. Stewart on identifying families that fail to thrive and therapeutic intervention. Jayne Antilla Tapia's model for family nursing, which involves assessing the family's level of development and functioning and using appropriate nursing actions is presented.

The sociocultural aspects of family nursing are considered and examples of different cultures are supplied. The importance of the nurse's use of herself as a tool to produce change is also emphasized in this chapter.

Spradley states that this book "is written primarily for nursing students, and their instructors, but has considerable relevance for practicing community nurses as well." This reviewer agrees with her and recommends this book for reading.

How to Keep Your Family Fit and Healthy by Bonnie Prudden. 273 pages. New York, Reader's Digest Press, 1975. Canadian Agent: Toronto, Clarke, Irwin and Co.
Reviewed by Ellie Robson, Health Services Division, Douglas College, New Westminster, B.C. An exercise physiologist and a physiotherapist offered their comments about the book.

On reading the book, *How to Keep Your Family Fit and Healthy,* one catches the contagious spirit that better-fitness could be for me, and not as difficult as thought.

The comment, "stay fit at all costs so that you may retain two things: Your independence and your dignity," adds a note of the importance to this pursuit. The physical fitness goal, " . . . to feel as good as possible and to perform well in many activities," is suggested in the book. This can be sustained by striking a balance between strength and flexibility.

The book deals with fitness for the young and old. We are asked to take an inventory of ourselves and then to rate ourselves against the outlined tests. If we fail, or need improvement, corrective exercises are prescribed.

Comments: A great deal of emphasis is given to fitness of the young, and considerably less to the other age groups, however those suggested are good.

The Kraus-Weber test for minimum muscular fitness is suggested for use by all groups, but a word of caution needs to be added regarding the upper and lower back test. Most physiotherapists do not approve of such movement for older people or those with a history of back problems.

Mention should be made in the book that it may be impossible for people with long legs, and short arms and trunk to accomplish the Flexibili test. These people may still have ve good flexibility in hips and back, bu will never, because of their body structure, be able to touch their toe nor should they be encouraged to d so.

Most experts agree that there a 3 aspects of fitness: flexibility, strength, and cardiovascular endurance or stamina. The book contains excellent sections on strength and flexibility, but practica ignores cardiovascular fitness, with only one-and-a-half pages on joggi and a few suggestions for other "c- activities, e.g., like walking to work Since heart disease is the number o killer for men over forty and is rising a a threat to women, at least equal emphasis, if not more, should be placed on aerobic conditioning.

The test for vital capacity is no good guide to better fitness. Vital capacity does not change very noticeably in the average person w undertakes a conditioning program What does improve is the oxygen-carrying capacity of the blo and the distribution of blood throug the capillaries during exercise. A simpler, but better indicator of cardiovascular function is the recove rate of the heart after exercise.

This reader dislikes the author discussion and suggestions for treatment related to medically defin conditions as fibrositis, bursitis, an tennis elbow. The diagnosis of suc conditions is beyond that of the lay competence. Most physiotherapists would agree that a dangerous precedent would be set if some peop used the author's suggestions of treatment, e.g. a coolant spray for muscles in spasm, exercise past a person's pain response, and deep massage for tension areas.

Nevertheless, I do recommend this book. Prudden is a motivator wh has been able to reach the genera public and give leadership to people move toward better health. Particularly to nurses who are interested in strengthening their role as health promoters, this book will b resourceful.

Medical Surgical Nursing 6ed. by Kathleen N. Shafer, Janet R. Sawyer, Audrey M. McCluskey, Edna L. Beck, and Wilma J. Phipps. 1032 pages. Saint Louis, The C. V. Mosby Company, 1975. Canadian Agent: Toronto, Mosby.
Reviewed by Julia D. Quiring, Associate Professor, School of Nursing, University of British Columbia, Vancouver, B.C.

The sixth edition of *Medical Surgical Nursing* has been greatly improved in format and is fast becoming a true reference book in both physical (it is getting heavier) and content sense.

Phipps, primary revision editor, indicates that many changes have taken place "in medical and health care, and in the practice of nursing." This edition has been developed to reflect these changes by placing an increased emphasis on physiological deviations from the normal and on the role of assessment. One specific addition has been a chapter on "Ecology and Health." Two chapters in edition five have now been combined into one on musculoskeletal injuries and disorders and the neurology chapter has been updated.

It is definitely apparent that the terms assessment and intervention have been utilized, though not consistently in every chapter. The use and identification of assessment detail in the chapter on neurologic assessment is useful, though new pictures of some specific positive and negative findings might make it more useful. Sections denoting some aspects of the nursing role are indicated in various chapters, and this does clarify some specific nursing activities and interventions. Though, as is common in textbooks, the specified nursing activities are quite conventional.

The chapter on ecology presents pertinent information related to health concerns, e.g., water pollution and radioactivity. Some detail specifying the entry site as body surface (for radioactivity), digestive tract (for food additives), and respiratory tract (for inhaled chemicals) provides useful information. This chapter would be improved, if the number of line and bar graphs and other schemata were reduced, and a section that included illustrations showed how the use of assessed data or potential health hazards could be used by the nurse either in health teaching or in health promotion/restorative activities. One section in this chapter is titled "Perspectives for Human Health," however, the content included here is so general that it is difficult to dissect specifics as to what the role of individual nurses is in promoting ecologic health.

The chapter modifications in this edition seem fairly minor. The neurology chapter has been expanded and can be used as a general reference. Combining musculoskeletal injuries and disorders does not substantively change the content.

This book should be primarily useful as a reference book for those in hospital settings. The organization of the book continues to follow a body systems pattern. Though the authors express concern for reflecting health aspects, following the medical (illness) model necessitates the major thrust toward restorative aspects of health care.

Man, Microbes and Matter by Bartley C. Block. 801 pages. New York, McGraw-Hill, 1975.
Reviewed by Mr. David Khokhar, Halifax Infirmary School of Nursing, Halifax, N.S.

Man, Microbes and Matter seems to excel its predecessors. It achieves its objectives from the learning perspective.

The subject matter is adequately treated, and one is particularly impressed with the fact that this text contains many areas that are often omitted, e.g., detailed descriptions of the periodic table of elements and the incorporation of integrated scientific facts from all branches of basic sciences.

The main points in each chapter stand out and are clearly and concisely explained; this facilitates



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Books

both learning and teaching. Applicable to nursing and the allied health professions, is a discussion of the latest basic chemicals, biochemicals, and microbiological principles. Excellent illustrations are offered but, at times, are too complicated.

As this textbook is intended to satisfy all basic science requirements of university freshmen in health programs; it is far too advanced for the 2-year diploma nursing course, or any other courses offered to paramedical personnel in a hospital setting. It is too complicated in its explanations, phraseology, and terminology. However, it would be an asset as a reference book.

Appendices, glossaries, brief introductions to chapters, and "search and reason" items that require students to independently search out information, are not included.

On the whole, this is the best integrated basic science textbook that one could find for a particular use i.e., integrated courses offered in the health professions. The material is sufficient and presented in an interesting way, generating student interest and motivation.

Nurses and Management by M. Schurr. London, The English Universities Press Ltd., 1975. 83 pages.
Reviewed by Gwen Greig (Cornthwaite), Director, Nursing Education, Grace General Hospital, Winnipeg, Manitoba.

This book is designed to teach nurses management skills. It would be a practical book for teachers of nursing and head nurses who are concerned with teaching managment or with the actual day-to-day management of a unit.

Of benefit to the teachers of the subject, three chapters are presented as introduction, explaining the meaning of management, why it should be a part of nursing and how learning can take place by good management.

The remaining chapters are situations to be studied and discussed by the group of learners. These chapters are most helpful, as they deal with organization and planning, resources, presentation of a case, implementation of change, communication and personnel management.

The book definitely has a British point of view and this could be a drawback, as some of the situations, terminology and government references might be foreign to Canadians. However,this does not distract from the overall content of the book.

Appendix II offers examples of programs for management courses and appears to be most helpful to head nurses or directors of staff training.

This book would be best used as a reference tool rather than a text book.

Public Health and Community Medicine 2ed. by Lloyd Burton and Hugh Smith Baltimore, Williams and Wilkins, 1975. 572 pages.
Reviewed by P.Y. Abraham, Assistant Professor, School of Nursing, University of Windsor, Windsor, Ontario.

The health maintenance of an individual is his own responsibility but the health maintenance of a community is the responsibility of the health professionals including governments, voluntary and private organizations (community health team). The prime concern of this health team is to maintain and promote the wellness of the community. This can be achieved through preventing and/or minimizin the effects of community problems related to health.

In public health, problems are n longer restricted to infectious diseases. Public health deals with ar problems that affect the health of a community. This book discusses nc only the possible problems, but als the community, its resources and environment, and their importance maintaining health. Chapter four explains the health indices, and oth tools that are used in public health.

A closer look at the contents o this text indicates that it is not writte for a specific group of health professionals, e.g., nurses, doctors and epidemiologists. The topics in each chapter are adequately discussed without the intricate detail Yet for those who are interested in details, a bibliography of references given at the end of each chapter.

This book can serve as an introductory text for a community health service course or as an upda for those who are already in public health.

Library Update

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Nurse Practitioner for community clinic. Start June 1, if possible. Contact: Beatrice Baker at 438 Lewis Street, Ottawa or call 1-613-233-2187.

Childrens summer camps in scenic areas of Northern Ontario require **Camp Nurses** for July and August. Each has resident M.D. Contact: Harold B. Nashman, Camp Services Co-op, 821 Eglinton Avenue West, Toronto, Ontario, M5N 1E6.

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Director of Nursing required for modern, fully equipped 28-bed hospital, with two Medical and one Dental Staff. Accommodation available in Residence if single. To commence duties July 1, 1976. Apply to: Administrator, Kipling Memorial Union Hospital, Box 420, Kipling, Sask. S0G 2S0.

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Texas wants you! If you are an **RN,** experienced or a recent graduate, come to Corpus Christi. Sparkling City by the Sea . . . a city building for a better future, where your opportunities for recreation and studies are limitless. Memorial Medical Center, 500-bed, general, teaching hospital encourages career advancement and provides inservice orientation. Salary from $802.53 to $1,069.46 per month, commensurate with education and experience. Differential for evening shifts, available. Benefits include holidays, sick leave, vacations, paid hospitalization, health, life insurance, pension program. Become a vital part of a modern, up-to-date hospital, write or call: John W. Gover, Jr., Director of Personnel, Memorial Medical Center, P.O. Box 5280, Corpus Christi, Texas, 78405.

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Indications: Treatment of infected or potentially infected burns, crush injuries, lacerations. Also varicose ulcers, bedsores and ulcerated wounds.

Contraindications: Known allergy to lanolin or framycetin. Cross-sensitization may occur among the group of streptomyces-derived antibiotics (neomycin, paromomycin, kanamycin) of which framycetin is a member, but this is not invariable.

Precautions: In most cases absorption of the antibiotic is so slight that it can be discounted. Where very large body areas are involved (e.g. 30% or more body burn), the possibility of ototoxicity being eventually produced should be considered. Prolonged use of antibiotics may result in the overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Dosage: A single layer to be applied directly to the wound and covered with an appropriate dressing. If exudative, dressings should be changed at least daily. In case of leg ulcers cut dressing accurately to size of ulcer and when infected stage has cleared, replace by non-impregnated dressing.

Supplied: A lightweight, paraffin gauze dressing impregnated with 1% framycetin sulphate B.P. Sofra-Tulle also contains anhydrous lanolin 9.95%. Available in 2 sizes: 10 cm by 10 cm sterile single units, cartons of 10 and 50; 10 cm by 30 cm sterile single units, cartons of 10. Store at controlled room temperature.

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The School of Nursing
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Post — Basic Course in
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Registered Nurses currently licensed in Manitoba or eligible to be so licensed.

The course is of nine months duration September through May and includes theory and clinical experience in hospitals and community agencies, as well as four weeks nursing of the mentally retarded.

Successful completion of the program leads to eligibility for licensure with the R.P.N.A.M.

For further information please write no later than June 15/76 to: Director of Nursing Education, School of Nursing, Box 9600, Selkirk, Manitoba R1A 2B5

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DOUGLAS HOSPITAL CENTRE
Opportunity for

NURSES

To join the team on a new observation unit for anglophone and francophone population of Verdun, LaSalle, Ville Emard and Pointe St-Charles.

For further information, please contact:

Mme. Micheline Leblanc
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Verdun, Quebec
H4H 1R3
Tel: (514) 761-6131, ext. 112

NOTICE

To all graduates of "Hotel-Dieu l'Assomption" and "Dr Georges L. Dumont Hospital" School of Nursing.

There will be a reunion of "L'Amicale"

Place: Moncton, N.B.
Date: July 3, 1976

For more information and registration forms, contact:
Mrs. Diane Benoît
76 Lefurgey Ave
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Nursing Home Director of Nursing

A new eighty bed home opening October, 1976 with a staff of fifty-five located in a residential area in the immediate proximity of the new Saint John Regional Hospital needs a Director of Nursing. The successful applicant will be responsible under the Administrator for the day to day provision of nursing, personal and supervisory care to the residents. Employment will commence in early summer 1976 and the successful applicant will be involved in planning and policy making decisions. Salary negotiable.

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Registered Nurse General Duty OR

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Director of Nursing
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B0V 1A0

Director School of Nursing

The University of British Columbia

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Each applicant should send a curriculum vitae and the names of three referees by May 31, 1976, to: Dr. W. D. Liam Finn, Dean, Faculty of Applied Science, The University of British Columbia, 2075 Wesbrook Place, Vancouver, B.C., V6T 1W5.

Co-ordinator

Co-ordinator required for a 340-bed acute care hospital in Central British Columbia to be responsible for the related services of the O.R., P.A.R., Daycare Surgery and Emergency Departments. The position will include both clinical and administrative responsibilities.

Salary per RNABC Contract.

For further information contact:

Director of Nursing
Prince George Regional Hospital
Prince George, British Columbia
V2M 1S9

Foothills Hospital, Calgary, Alberta

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Applications now being accepted

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1403 29 St. N.W. Calgary, Alberta
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In a progressive Southwestern Ontario Health Unit serving an urban and rural population of nearly 300,000. Excellent fringe benefits.

Assistant Director of Nursing to be primarily responsible for inservice education and program development. This is a new senior position within the nursing division of this agency. Applicants should have a minimum of five years nursing experience, including some in public health nursing. Bachelor's degree considered, Master's degree preferred. Salary competitive.

Supervisor in Public Health Nursing to be primarily responsible for public health nurses in group-oriented program.

For further details contact:

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Middlesex-London District Health Unit,
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London, Ontario N6B 1B9

Head Nurse

with preparation and/or demonstrative competence in **Psychiatric Nursing and Management** functions, required for Head Nurse appointment. To be responsible for participation in the organization, initiation, and the management of a **New Psychiatric In-patient Unit.**

Please apply, forwarding complete resume to:
Director of Personnel
Stratford General Hospital
Stratford, Ontario
N5A 2Y6.

Department of Health
Province of Newfoundland
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Nurses

Applications are invited from graduate nurses for appointment as STAFF NURSES in Cottage Hospitals with bed capacities ranging from 20 - 60.

Applicants must be eligible for registration with the provincial nursing association.

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Applications should be addressed to:

Director of Nursing
Cottage Hospitals Division
Department of Health
Confederation Building
St. John's, Newfoundland

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Registered Nurses and Registered Nursing Assistants

- 255-bed General Hospital in the West of Montreal
- Clinical areas include Progressive Coronary Care, Intensive Care, Medicine and Surgery, Psychiatry.

Interested qualified applicants should apply in writing to:

Queen Elizabeth Hospital of Montreal Centre
Director of Personnel
2100 Marlowe Ave., Montreal, Quebec
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Applications are invited for the position of Associate Executive Director, Canadian Nurses' Association, Ottawa.

Candidates must be members of the Canadian Nurses' Association, have a master's degree or equivalent, have at least five years' administrative experience, and be bilingual.

Interested applicants are asked to submit their curriculum vitae, in confidence, to:

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Mr. I. Rosenfeld
School of Nursing
McGill University
3506 University St.
Montreal, Quebec H3A 2A7

The Registered Nurses' Association of Nova Scotia

invites applications for the position of

Executive Secretary

The applicant should have a broad nursing background, administrative experience and university preparation, preferably at the Master's level. A background in professional association activities would be an asset.

Applications for this position will be accepted until September 1, 1976.

For complete information, including job description and salary range, write to:

President
Registered Nurses' Association
of Nova Scotia
6035 Coburg Road
Halifax, N.S. B3H 1Y8

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Director, Nursing Service
Jewish General Hospital
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H3T 1E2

University Hospital of the West Indies

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Applications are invited from suitably qualified Registered Nurses for the following posts at the University Hospital of the West Indies which is a Teaching Hospital of 500 beds and also conducts a School of Nursing with a complement of 300 students.

A. Sisters

1 Operating Theatre
2 Paediatrics *(For Surgical Ward)*
3 Dermatology

Applicants must:

1 Be dual trained and hold post-graduate certificates in the relevant specialist field.
2 Have managerial experience and/or evidence of post-graduate managerial training.

Salary in the scale of: $4440 x 240 - 5640 per annum

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Applicants must be registered or registrable Nurses with special training in Intensive Care.

Salary in the scale of: $3240 x 180 - 4500 per annum

Applications stating full details of Nationality, age, marital status, qualifications and experience should be sent to the: Director of Nursing Services, University Hospital of the West Indies, Mona, Kingston 7.

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Registered Nurses
Nursing Assistants

Our patient population consists of the baby of less than an hour old to the adolescent who has just turned seventeen. We see them in Intensive Care, in one of the Medical or Surgical General Wards, or in some of the Pediatric Specialty areas.

They abound in our clinics and their numbers increase daily in our Emergency.

If you do not like working with children and with their families, you would not like it here.

If you do like children and their families, we would like you on our staff.

Interested qualified applicants should apply to the:

Director of Nursing
Montreal Children's Hospital
2300 Tupper Street
Montreal, Quebec, H3H 1P3.



Nursing Education at
Royal Prince Alfred Hospital

Sydney, NSW, Australia

Royal Prince Alfred Hospital is Australia's largest teaching hospital (1532 beds) and the most highly specialised acute hospital in the country. It is also a teaching hospital of Sydney University, which it adjoins.

Graduate nurses at RPA get wide clinical experience in the most modern and advanced medical environment available in Australia. They also undergo continuous in-service education to ensure that their theoretical knowledge keeps pace with their clinical experience.

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If you would like to join Royal Prince Alfred Hospital either as a graduate member of the staff or as an entrant for either the basic training or post-graduate courses, please write to or telephone:

Ms Margaret Nelson
Director of Nursing
Royal Prince Alfred Hospital
Camperdown, NSW 2050
Tel: Sydney 51-0444.
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Contact your nearest Canadian Forces Recruiting Centre or write to:
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National Defence Headquarters
P.O. Box 8989
Ottawa, Ontario
K1A 0K2

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City of Vancouver

Director Of Community Health Nursing

The City of Vancouver Health Department, a member of the Metropolitan Health Service of Greater Vancouver, is seeking a Community Health Nurse to plan, develop, administer, supervise and evaluate a comprehensive community health nursing program for a population of 500,000. The successful applicant will be expected to continue in the development of innovative programs and work in conjunction with other professionals to improve the preventative health services to the community.

The requirements for the position are a Bachelor's Degree in Nursing, including or supplemented by training in community health nursing and post-graduate courses at the Master's level in administration, and supervision in community health nursing. Preferably a Master's Degree with content in supervision and education and a major in administration. Considerable experience as a Community Health Nurse, especially in the various administrative and supervisory levels.

The monthly salary for this position is $1833 to $2246 per month (1975 rates), depending upon qualifications and experience. This position will become vacant in late 1976 or early 1977.

All applications should be made on "Application for Employment" Form Pers. 35 and returned, as soon as possible, preferably together with a detailed resume, to the Department of Personnel Services, 453 West 12th Avenue, Vancouver, B.C. V5Y 1V4. Please quote competition number R-1501. This position is open to both male and female candidates.

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Previous clinical and administrative experience required. Post graduate courses and administrative education preferred. To commence June 1st, 1976.

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Previous clinical and administrative experience required. Advanced formal preparation at a University level preferred. Responsible for the Nursing Department on evenings, and nights; clinical resource person on days. To commence September 1, 1976.

Personnel policies in accordance with R.N.A.B.C. Contract. Must be eligible for B.C. registration.
Apply sending complete resume to:
Director of Personnel
Vernon Jubilee Hospital
Vernon, B.C. V1T 5L2

Government of Newfoundland & Labrador
Mental Health Nursing Consultant

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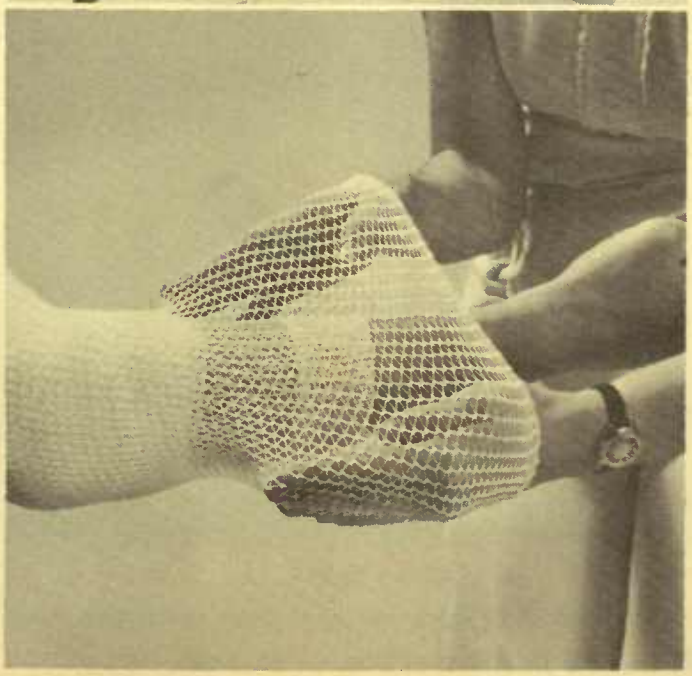
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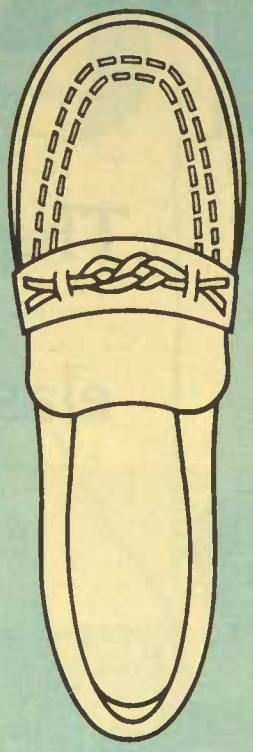
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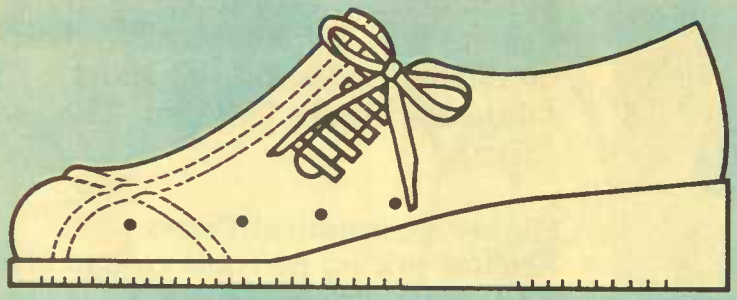
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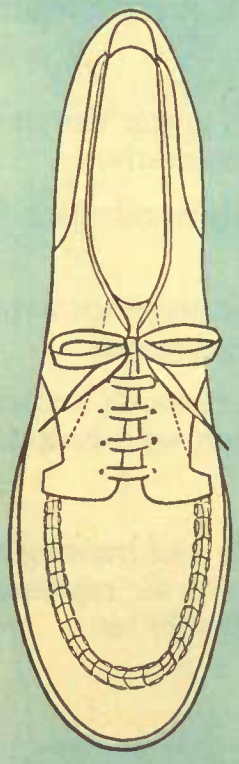
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The final hurdle for nursing students across Canada is the examination for nurse registration/licensure set by the Canadian Nurses Association Testing Service. This month *The Canadian Nurse* salutes the RN's of the future who are writing these all-important exams in June. The cover photo, courtesy of *The Globe and Mail,* Toronto, shows a group of 1975 graduates during their exams last year.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses' Association.

ISSN 0008-4581

Indexed in International Nursing Index, Cumulative Index to Nursing Literature, Abstracts of Hospital Management Studies, Hospital Literature Index, Hospital Abstracts, Index Medicus. *The Canadian Nurse* is available in microform from Xerox University Microfilms, Ann Arbor, Michigan, 48106.

The Canadian Nurse welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-space. Send original and carbon. All articles must be submitted for the exclusive use of *The Canadian Nurse.* A biographical statement and return address should accompany all manuscripts.

Subscription Rates: Canada: one year, $8.00; two years, $15.00. Foreign: one year, $9.00; two years, $17.00. Single copies: $1.00 each. Make cheques or money orders payable to the Canadian Nurses' Association.

Change of Address: Notice should be given in advance. Include previous address as well as new, along with registration number, in a provincial/territorial nurses' association where applicable. Not responsible for journals lost in mail due to errors in address.

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Perspective

Every writer who submits an article to The Canadian Nurse *has something original to offer readers. This makes opening the mail a little like Christmas every day and adds greatly to the editor's appreciation of what nurses across the country are thinking. The number of submissions that can be accepted is, unfortunately, limited. Of the ones that do get into print, most end up as an article, or maybe a letter-to-the-editor. The one below is an exception: it's on this page because I think the challenge it offers health professionals, while not new, is important. It was submitted by* Patricia Ford of Thunder Bay, Ontario *and here is what she wrote:*

What I have to say is going to be as popular as shooting puppies but, in the past year, I have become convinced that exercise is not something exclusively for athletes or the educated few who pound around university tracks. Rather, it is a *biological necessity:* to live to your potential both quantitatively and qualitatively you must exercise.

A vivid example occurred recently when a 38-year-old man with a myocardial infarction was admitted to the Intensive Care Unit where I was working. Right away, some of you will suggest that his heart attack was due to some quirk of cholesterol functioning or a stressful situation. Perhaps, but I doubt it. Studies of three groups of people known for their longevity in Kashmir, Russia and Ecuador, found a high level of physical activity was common to all. The gerontologist involved, Dr. Alexander Leaf, was amazed at the exertion displayed by men and women over 100 years of age. For those who may quibble about their true ages, he states — "It is the fitness of many of the elderly rather than their age that impresses me." These people do not possess some special gene or immunity which protects them from aging . They appear to suffer from many of the same cardiovascular diseases that we do, but their heart muscle is so superior due to activity, that their heart attacks are silent.

Consider the human potential this represents. Imagine not just surviving to the age of eighty or ninety, shuffling around the halls of a nursing home, but really living, being able to walk miles, swim and enjoy your grandchildren. What is more exciting is that this possibility is within our grasp. Why should we passively accept a reduced life expectancy just because of the life style technology forces upon us? Why should we allow technology to fatten us like sedentary cattle for a futile kill? We have control over our lives and we must exercise that control to live. Of course, it takes some effort: slick advertising implores us to drive everywhere; the slightest smell of sweat is reason for social ostracism; parents who tell their children to walk a mile to school are cruel; and our highways say "No Bicycles Allowed."

What can you do? First, recognize that man has survived as a species not in spite of hardship but because of it. Exercise should be recognized not as an occasional indulgence for a flatter stomach or firmer thighs but a daily biological necessity — whether it is running, swimming, skating, jogging or whatever. Exercise must be approached with intelligence, but as Astrand the noted Swedish physiologist indicated, a checkup by a physician is more important for those who are going to continue a sedentary existence than for those who are going to start exercising. Depending on your situation, it will probably take you 45 minutes per day including a shower afterwards, to maintain a reasonable level of physical fitness. And, it must be regular. Also, every chance to walk in your daily routine should be taken. Can you walk to work? Too far? Then get off the bus one mile from work and walk the remaining distance. You will not only look and feel better but you will be controlling your own destiny.

If you value your life, you will exercise. Only you can increase the quality and quantity of your life — for less than an hour a day you can add years to what is presently being programmed as your life expectancy. Run for your life and avoid the slaughter!

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Herein



Doreen Scott, the author of this month's "Connection," is program coordinator for the Department of Nursing at the Alberta Hospital, Ponoka, Alberta. She obtained her RN from Calgary General Hospital some time ago and last November received her B.Sc. in Nursing from the University of Alberta. She describes her present work as "exciting and challenging and I love it." She and her family live on a farm and her activities these days include work on a novel which will feature a nurse.

Breast cancer CAN be beaten . . . but only if nurses make full use of their caring qualities to help women detect and cope with this disease. To learn more about "getting in touch" with these patients, read Ada Butler's feature story "Breast Cancer" beginning on page 17. We suggest that, along with this article, you read "Thermography" by Monica Bacon as well as this month's audiovisual feature section.

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Input

A bureaucratic battle lost

Beverly MacLellan's article "Matthew My Son," (March, 1976) should occasion no surprise among at least one group of Quebec citizens. I refer to those of us who struggled so valiantly, and so vainly all through the summer and fall of 1973 to convince the Quebec Ministry of Social Affairs under Claude Castonguay, that the closure of the Catherine Booth Hospital with its family-centered maternity care services, was a grave and serious error in judgment. It is difficult, well nigh impossible to refrain from saying "I told you so!"

What happened to Beverly and Keith during "prepared childbirth at the General" was good. What happened to Beverly, Keith and Matthew during the next four days was not tragic, but it *was* sad, and as a nurse I feel ashamed and obliged to say to them in the name of nursing "I'm sorry. It should not have been like that. It would not have been like that at the Booth."

Thirty thousand Quebec citizens in 1973 saw fit to sign a petition asking the Quebec government not to close the hospital. Nobody listened. Dr. Sidney Lee, Associate Dean (Community Medicine), McGill University, advised the ministry then: "These units must be effective in both the human and scientific domains. We don't want hospitals which fail in either of these respects....Science without warmth and kindness is unacceptable to our views of what medicine is and should be." Noble sentiments, but one is forced to ask as Susan Pomerantz did in a Montreal Star editorial regarding the Booth closure "What justification is there for ending maternity care *in the one place* where treatment on the human level is as highly emphasized as treatment on the medical level; where the mother, the individual is still as important as the mother, the patient?"

In 1973 we asked *The Canadian Nurse* for moral and editorial support in our battle, and were told that this sort of action would be against editorial policy. Coverage of our loss of this small battle in a big war, was less than negligible, but as Canadian nurses, how could we prevail against the "editorial policy" of our own professional journal? And now, in March of 1976, you editorialize that for Beverly MacLellan "the support and encouragement that she needed....was not available when she needed them most." So, I ask you what else is new? *WHEN* will you people open your eyes and honestly confront yourselves and your readers with the truth about what is happening to people in hospitals at the hands of the "health professions?"

— Mary E. Hall, B.A., R.N., D.N. Ed., Chateauguay, Quebec.

The editor replies: Your charge that we are not "telling it like it is" is a serious, — indeed, a fundamental one — for a professional journal that exists primarily to do exactly that. In an editorial last January I tried to explain my commitment to this task. That is why the decision was taken to include an article by a non-nurse (Beverly MacLellan) in the March issue. We thought it was essential for the profession to see how people on the receiving end of health care perceive the system and the providers. It was regarded by the editorial staff as a step in the direction of "telling it like it is" rather than simply describing the ideal in maternal/child care.

Whether the profession chooses to work together for the improvement of the health care system depends upon its members. Their journal is willing — indeed anxious — to provide the necessary forum.

March issue a winner

It is a change to write someone a letter to say what a good list of articles appeared in the March, 1976 issue of *The Canadian Nurse*. The diagrams in " A Practical Guide to Successful Breast-Feeding" were excellent. I also appreciate your printing Beverly MacLellan's article.

— L. Cliffe, Public Health Nurse, Delta, B.C.

I enjoy your new look, especially the fact that each issue appears to have a theme.

March's issue was of particular interest to me since I am a nurse and also a nursing mother. It's very encouraging to see that nurses are becoming more knowledgeable about the subject since I know from personal experience and the experience of others that too often the nurse has been responsible for the mother getting off to a bad start.

I do have some argument with Taggart, though. She says "Meticulous washing of the breasts — is necessary before and after each feeding in order to avoid infection." If one keeps one's clothes clean, nature will keep the breasts clean. A daily bath with warm water is plenty and of course no soap or alcohol on the breasts. The purpose of the Montgomery's Tubercles is defeated if one follows a routine of cleaning the nipples before and after every feeding — that purpose being to keep the nipples clean yet supple with their wax-like secretions. In fact this regime of cleaning could easily lead to sore, cracked dry nipples, (even if creams are used) leading to a stasis of milk thus an infection. Free-flowing milk is by far the best prevention of mastitis. A good healthy neonate is in no danger of infection from his mother's breasts unless she has T.B. or whooping cough, of course.

What of the mother whom the nurse suspects is not personally clean. Well, let that nurse be thankful the woman is nursing her baby. Her milk will be fresher and more sterile than any formula she could probably make at home. Right?

I think that breast-feeding, among its other advantages, is the simplest, most convenient way of baby feeding. Let us, as nurses, keep it that way.

— Judith Vestre, Saskatoon, Sask.

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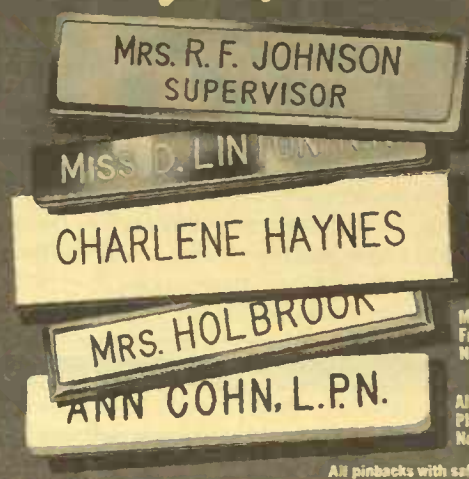
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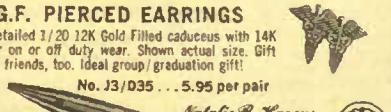


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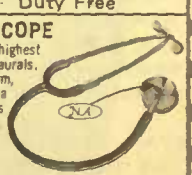
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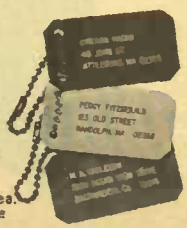


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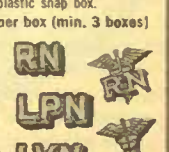


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Input

More tips for nursing mothers

As a nurse and La Leche League Leader, I was very pleased with the articles on Breast-feeding and Mastitis *(March, 1976).* The education of case room and postpartum nurses is essential since their attitude can "make or break" a nursing relationship. I feel it would be a great service to nursing mothers if information about the local La Leche League was routinely handed out at all hospitals. Most problems in the management of lactation are not medical in nature and could be handled by an experienced nursing mother rather than bothering the hospital nurses after discharge.

I would like to make a few specific comments.

Preparatory Exercises: We find it helpful to have the mother actually express a few drops of colostrum daily from each breast in the last trimester. There is some feeling that this helps to open the milk ducts as well as giving the mother practice in hand expression.

Hygiene: I feel "meticulous washing" is really unnecessary. Simple rinsing with *plain* water should be enough.

Drainage: If a mother can nurse her baby every two hours or oftener, her problems are greatly reduced. I question the need for emptying the breast after each feeding if the baby has not nursed for half an hour. Not many newboms have the physical stamina to nurse effectively for that length of time. We advise that if baby tends to fall asleep after ten minutes on one side, he be allowed five to seven minutes on the first side and as long as he likes on the second. Alternate breasts are offered to begin each feeding. Studies show that an infant can remove 90 percent of the milk in a breast in five to seven minutes.

At-Home Instructions: should include advice about handling a "growth spurt." This often occurs at about six weeks of age. Baby suddenly wants to nurse every hour to one and a half hours . This is simply his method of increasing the milk supply to meet the new growth demand. This frequent nursing will last at the most 72 hours and maybe only 24-48 hours. If allowed to nurse as often as he wants, he will resume a more reasonable schedule as soon as the milk supply increases sufficiently. This is the time when Mother panics, thinking she is losing her milk and reaches for the bottle which defeats the whole process.

We have found that always offering both breasts at each feeding is best. Starting on the side she finished on last time ensures adequate emptying of each breast every other feeding.

Lastly, though a "healthy child with a good sucking reflex" is a great help to successful nursing, it is not essential. Many premature, cleft lip and palate, and otherwise compromised infants have been successfully nursed — much to the delight and pride of the anxious and deeply concerned mothers.

Once again, thank you for opening R.N.'s eyes to a much needed area of information.

— *Cheri Purpur, Red Deer, Alta.*

Non-support

Thank you for the article "Matthew My Son" and the articles on breast-feeding. When I trained in the forties great efforts were made to teach us to help mothers breast-feed. However, in 1947, when I successfully was breast-feeding, on departure from the hospital where I trained, my obstetrician handed me a formula to take home. When I told him I was breast-feeding, he remarked: "Oh you'll get tired of that soon." Ever since then I have been appalled at the attitude of many doctors regarding breast-feeding. Nurses have always been taught to work under the direction of doctors. Is it any wonder that the emphasis on teaching nurses to help mothers breast-feed has decreased!

I hope there are enough doctors in Canada who are really anxious to have their patients breast-feed their babies that Canadian nurses can put into practice the fine lessons provided by Taggart.

— *Lois B. Hord, B.A., R.N., Québec, Qué.*

Help for abortion patients

As a nurse and as a woman I take exception to "What are the bonds between the fetus and the uterus?" written by a male. *(Adamkiewicz, February, 1976).* This sort of article reflects a very narrow and provincial view that helps neither the patient nor the nurse. The idea of a womb being somehow outside the body and separate from the person who carries it, is extremely repugnant and anti-feminine. Surely in an age when women are struggling for their rights in all areas, the only national nursing publication in Canada can do better than to advocate such a position.

Our patients are having abortions, we must face this and deal with it as best we can. Do we want them to go back to dying or suffering (as I once witnessed) an abortion well-done, but without anesthetic? Legislation repressing the ability to get abortions will lead to this and will not help our patients.

Too often I have seen nurses display an absolute disregard for the feelings of their abortion patients because they (the nurses) felt it was wrong. How cold they were and how they left the patient even more empty and frightened than before. Surely if we are nurses we must be prepared to nurture and teach these women just as we nurture and teach our other patients. It is our professional responsibility to recognize our patients' needs and to put aside some of our feelings.

I am not saying that we should not deal with our feelings nor that we should work in areas which are distasteful and frightening to us. But we do not have to treat the abortion patient cruelly, nor do we have to advocate the legislation implied in your article. It seems to me that the patient should come before everything, and her reality is that she will seek abortion no matter what we feel.

— *Georgiana Kish, B.N., Montreal, Que.*

A woman's right

I thought I had encountered all the arguments of the anti-abortionists but Dr. Adamkiewicz's suggestion that the uterus be accorded extraterritorial status amazed me.

I certainly would not argue that the fetus has a different biological identity from that of its mother. When women refer to having rights over their own bodies they talk of the uterus, not the fetus, as being part of the female body. When society denies women access to abortion the fetus is given the right to occupy and use the body of another person — a right accorded to no other individual in our society.

Dr. Adamkiewicz states that the uterus protects the fetus from rejection by the mother's body. It is my understanding that the placenta is the organ which performs this function. The uterus is a female organ and as long as the fetus can only develop to maturity within the uterus, I believe that only the individual woman concerned should decide whether or not to continue her pregnancy.

— *Audrey C. Hall, Prince Albert, Sask.*

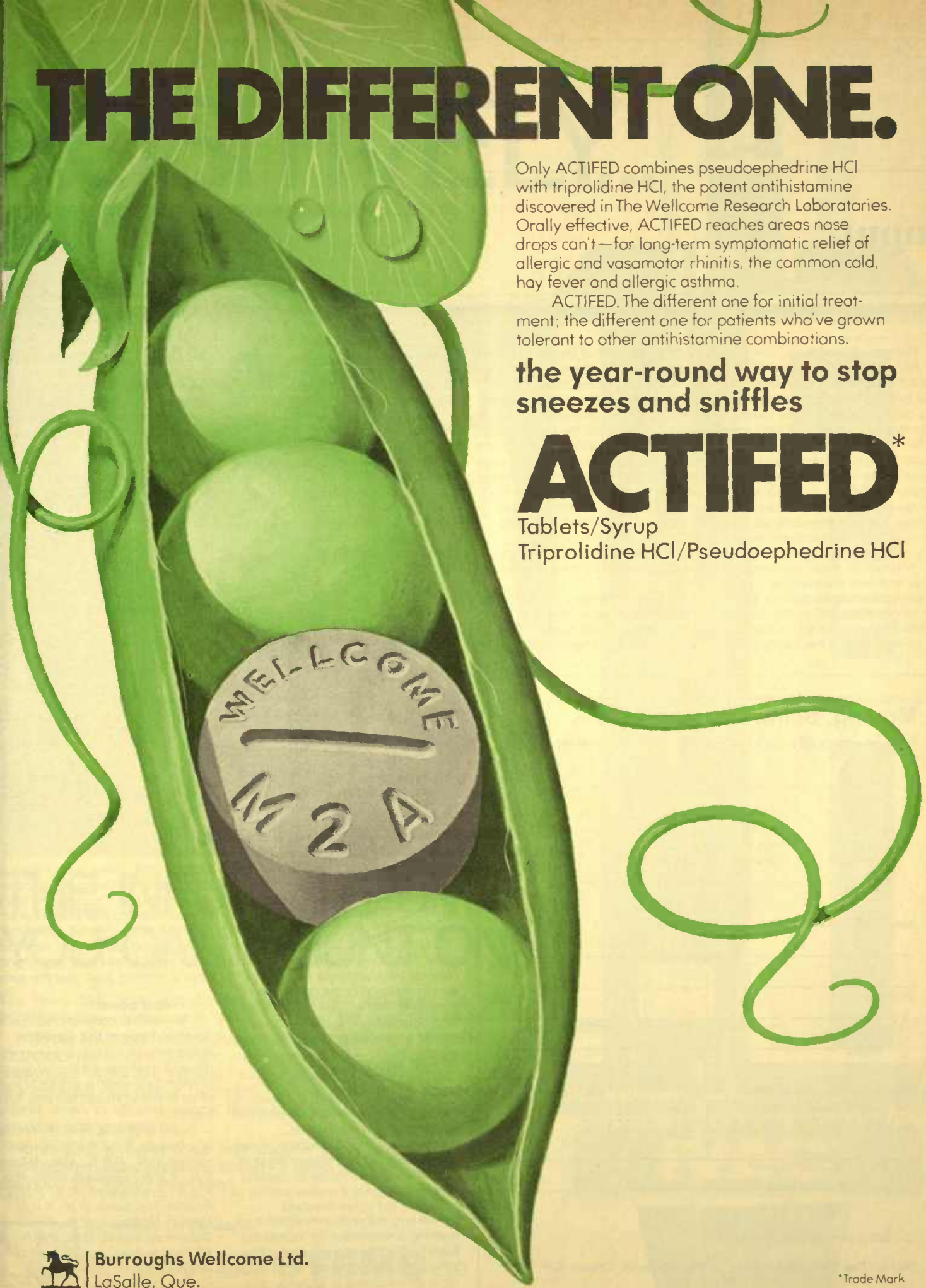
A question of drugs

I am Inservice Coordinator in a small 57-bed general hospital. Recently we have been made aware of the fact that most of the training schools and hospitals in our province do not train or allow RN's to administer certain parenteral medications such as iron preparations, magnesium sulfate and medications in oil suspension form. Many of our new RN's are refusing to administer these medications IM. Naturally we have become wary of these drugs. The problem is that we cannot find out from any source why hospitals and schools of nursing are not allowing these drugs to be given by supervised students or RN's. What, besides special methods of administration, is the danger? Are RN's now not capable of learning special techniques for the administration of certain IM medications? I consider an RN always responsible to be aware of and watch for reactions but this does not seem to be the problem.

— *Nan Holden, Shelburne County, N.S.*

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Input

Nurses' dilemma

Nurses in Ontario are worried about the government's decision to close hospitals in order to reduce health care costs. This decision is having a major impact on everyone involved in health care services, especially nurses. Thirty-six hundred nurses will graduate from community colleges and universities this year, but fewer than two hundred positions are open; for those, the new graduates will have to compete with unemployed nurses, many of whom have experience.

What will all these unemployed nurses and new graduates do? Does the government really believe that a well-trained nurse will be happy in an unskilled or semi-skilled job earning half or even less of her salary?

The Minister of Health states he understands the situation but these are the times we live in. Isn't it the government's responsibility to guide and direct? Ten years ago everyone wanted to increase the supply of nurses. At that time the Health Ministry should have worked out a long-range plan and tried to establish a balance between supply and demand. In 1971, or earlier, the government should have limited enrolment in nursing education. With the current unemployment situation, obviously the government did not look ahead in time.

Since the Ministry of Health has created the problem, they are responsible to assist nurses in finding new jobs within the health care system or in starting a new profession. The government should set up a task force to help nurses reestablish themselves.

It will be a difficult time; a lot of reexamining and setting of new priorities must be done. Our lifestyles will change, but it is up to us to make the best of it. Don't sit back and give up, or hope things will change by themselves. The problem has been created... *let's solve it.*

— Konrad and Nila Sadek, Cambridge, Ontario.

Nursing ed philosophy

In response to Stinson's "Frankly Speaking About Nursing Education," *(The Canadian Nurse,* January 1976) and the concept of national or regional centers: Anyone wishing training, education, or information, ought to go directly to the source. Teacher preparation should be in a school of education. Administrators should be prepared in a school of administration. Nurses should be prepared in a school of nursing. Teaching is a profession. Nursing is a profession. Nurse-teachers must have knowledge and skills from both professions.

In Canada we do not have health care. We only have disease care. Government "health care" schemes only pay for care of people who have demonstrated disease. It seems that no money is available for preventive medicine.

Up to a point, centralization has value. Probably there is need for both regional health science centers and smaller centers for the preparation of nurses. As long as patients are treated in various types of facilities, nurses should be prepared to work in these situations.

We need to take a hard look at "preparing," to the point of doing a needs assessment analysis. I believe that there are alternative solutions to the problems of inadequate preparation of nurse teachers. If part of the problem is lack of teaching skills, one alternative could be for nursing schools to employ a master teacher to work with the nurse-teachers.

In fact, the problem may be in the learning environment, or indeed the basic philosophy of nursing education. When one considers the continuing rapid development in all fields, and realizes that an individual has to work very hard to keep pace with advancing knowledge, techniques and procedures in specific areas of a profession (teaching and/or nursing), the job of a nurse-teacher seems almost impossible in the present structure.

— Jane C. Haliburton, Director of Education, Yarmouth Regional Hospital, Yarmouth, N.S.

CNJ by pony express

The date is April 7, 1976, and I've only just received the March issue of *The Canadian Nurse* in this morning's mail. I'm wondering why the delay? Most journals are out before time. Had I wanted to apply for a post, or attend any of the meetings mentioned in the "News," I would probably have been too late. I know we live to the West of the Rockies, but nowadays we don't have to rely on the pony express or the mule train. Pierre Trudeau must have thought B.C. important enough to be on the map, for didn't he come West to marry Margaret? My plea is, please let us have our professional magazine here before it is five weeks late!

— Grace Burrows, R.N., Brentwood Bay, B.C.

Editor's Note: I hear you. If there is anything more irritating than receiving a magazine late, it's producing one on time and finding that readers aren't getting it till much later. Have you taken a good look at your local post office lately? Does it by any chance have a hitching post near the door?

People power

We wish to commend you on the excellent issue of *The Canadian Nurse (March, 1976).* It was most refreshing to receive a journal oriented to infant care which is so vital to those of us in Public Health Nursing. Many thanks.

— Kathie Wdowiak, R.N., P.H.N, Ann MacDonald, R.N., P.H.N., Gwenda Hartlen, R.N., P.H.N., Mary Mercer, R.N., P.H.N., Elizabeth Watts, R.N., P.H.N., Eva Parsons, R.N., P.H.N., Heather McCleave, R.N., P.H.N., Patricia McManus, R.N., P.H.N., Genevieve Nason, R.N., P.H.N., M. Patricia MacLeod, R.N., P.H.N., Margaret Martin, R.N., P.H.N., Atlantic Health Unit, Department of Public Health, Nova Scotia.

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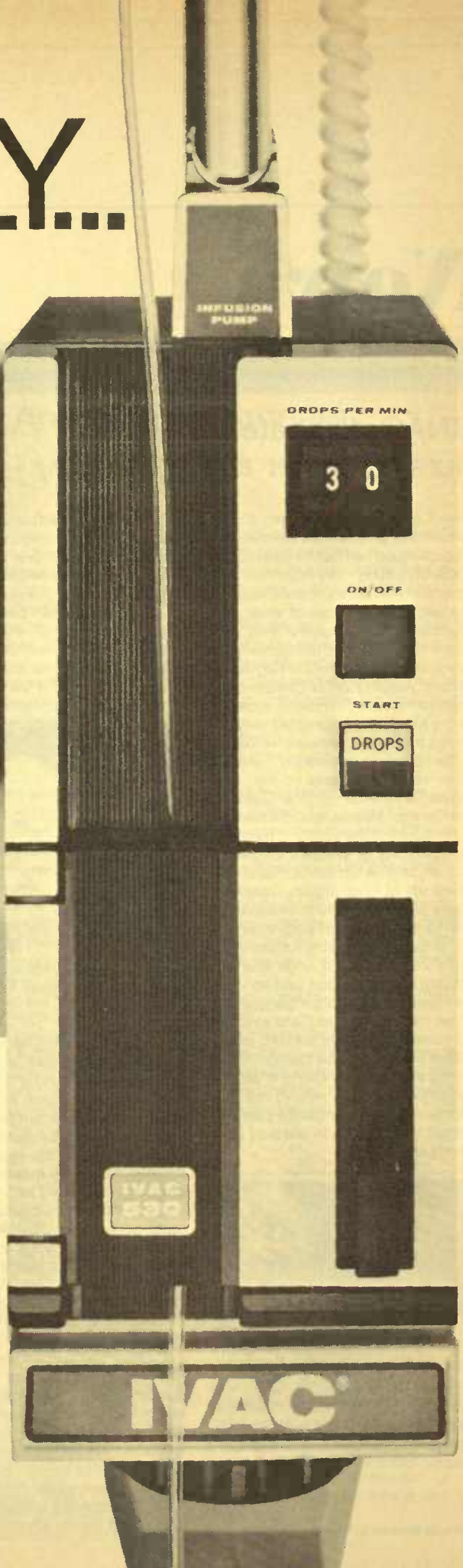
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News

RNAO delegates examine nursing power and process

One of Ontario's best known and loved nursing educators believes that the profession has lost its sense of the *whole* of nursing. "We have created a community of boxes related to our specialities, our places of work, our education and our roles in practice," Jessie H. Mantle, told delegates to the 51st annual meeting of the Registered Nurses' Association of Ontario in Toronto recently. "There is some caring within these boxes but very little across their walls because we defend our territories so ferociously," she said in her keynote address on the convention theme — "The Quality of Our Caring." Mantle, who is a member of the faculty of the school of nursing at the University of Western Ontario in London, is now on sabbatical at the University of Washington, Seattle, where she is enrolled in predoctoral studies in the area of gerontology.

She challenged the nurses in her audience to accept change and to develop a peer support system within the nursing community. "Because we are women and nurses," she said, "we still cannot guarantee that the patient will have access to the caring process but nurses who are willing to act as bridging agents can help to reduce fragmentation of the health care system if they learn to practice as a community."



Keynote speaker, Jessie H. Mantle (right) with RNAO assistant executive director, Doris E. Gibney.

Photos by Suzanne E. Emond

She also urged nurses to develop a positive self-concept about the profession and to work to increase nursing input into decision-making in health care. "We are grossly ignorant of what other health professions are doing and thinking," she charged. "Talk to your colleagues and learn to consult one another. Nurses must speak out but learn to do it effectively and appropriately."



Chairman of the Resolutions Committee, Margaret Kuchmak.

More than 1200 RNAO members and nursing students registered for the three-day meeting. Much of the discussion and action on resolutions was colored by recent health care cutbacks and curtailments in the province. Among the resolutions passed during the meeting was one directing the RNAO to "investigate ways to assist new graduates without opportunity for employment in nursing to maintain knowledge and skill relevant to current practice in nursing." Close to 3600 nursing students are competing this year in Ontario for an extremely limited number of openings.

Other resolutions were directed towards "identifying and demonstrating the effectiveness of a health maintenance system (a system directed towards improving health levels — i.e. keeping people well) and the creation of a citizens' advisory council "which would provide input for RNAO's response to health care needs and trends affected by social change."



RNAO president Norma Marossi.

President Norma Marossi described these as turbulent times for young graduates beginning careers and also for experienced nurses seeking employment. She reminded delegates of RNAO's historical interest in and contribution to the field of employment relations. She said that an employment referral service had become an essential service for nurses and one probably best met by the professional association.



Irmajean Bajnok, president-elect of the RNAO.

Executive director Laura Barr, in her report to the membership, described the essence of nursing as "*presence* — presence for three tours of duty, seven days a week, 52 weeks of each year. This presence is so essential that it is often required on a one-to-one basis. Is it any wonder that the bulk of hospital budget applies to nursing?" she asked. "We are a cluster of skills required to render the service needed. We do not depend on the expensive hardware demanded by other services."

Individual members expressed concern over the need to examine the nursing process in the light of recent cutbacks as well as the need for the association to support nurses at the bedside who may find that it is not possible in the future to provide adequate care. They also stressed the importance of demonstrating as a profession the effectiveness of alternatives to acute care.

Ontario to study two-year programs

A study to determine the effectiveness of the two-year community college training program of nurses in Ontario will be tendered shortly by the Ontario Ministry of Colleges and Universities.

Gerry Wright, the Ministry's Administrator of Health and Sciences Programs, says that the study will be an objective analysis of how well two-year nursing graduates perform on the job, with an aim to implement any changes indicated as soon as possible after the study's completion.

Wright says that the steering committee for the project includes representatives from various interest groups, including the College of Nurses of Ontario, the Ontario Hospital Association, the Registered Nurses' Association of Ontario, and the Ministry of Health. This committee will formulate objective questions and research specifications for the study.

The study will attempt to evaluate the effectiveness of the community college program, a program that has been the source of much opinion and controversy.

Before 1973, most nurses were trained in three-year courses given by individual hospitals under the College of Nurses of Ontario. The course was shortened to two years before the community colleges took over nursing schools in 1973.

The study will be contracted outside the Ministry, with its first phase expected to begin in June. The second phase, Wright says, will probably begin in September, to be completed hopefully, by spring of 1977.

Canadian Task Force Concludes Annual Pap Smears Not Necessary for Most Women

uch of the repetitive annual screening of women whose previous 'apanicolaou) smears have been normal is unnecessary. By reducing the equency of examination in such women and deploying the resources to oncentrate on women at risk, who presently are not being screened at all, anadian cervical cancer screening programs could become much more ffective without utilizing more resources than they do at the present time.

The views are those of a seven-member Task Force on Cervical Cancer creening Programmes, appointed by the Conference of Deputy Ministers of ealth following a meeting in December 1973. They are contained in a report ubmitted by the chairman of the Task Force to the Deputy Minister of Health nd Welfare Canada, the Hon. Jean Lupien. This report was published in the une 5, 1976 issue of the *Canadian Medical Association Journal* (vol. 114, o. 11). It deals primarily with frequency of screening, quality control and ollow-up mechanisms. Members of the Task Force reached a number of ignificant conclusions on the basis of their findings. Among them:

Squamous carcinoma of the cervix does lend itself to control by means f a cytological screening program.

There is evidence in Canada that:
– cytological screening programs are becoming effective in reducing nortality from carcinoma of the cervix;
– the extent of this reduction is directly related to the proportion of the opulation screened;
– the prevalence of abnormalities in an unscreened population is of the rder of 5.5 per 1000. If this population is reexamined the incidence of bnormalities is of the order of 0.5 to 0.7 per 1000.

A screening program will use resources most efficiently when it oncentrates on bringing women into the program and when the frequency of xamination is tailored to the degree of risk rather than when examinations re performed on the "customary" annual basis.

In considering the category of risk, the report concludes that:
– a woman is *"at risk"* as soon as she becomes sexually active;
—within this group, a *"high risk subgroup"* exists, consisting of women who began sexual activity early, especially with multiple partners;
— a woman may be assumed to be *"no longer at risk"* after reaching the age of 60, having participated regularly in the program, without having had a smear show significant atypia;
— women who have never been sexually active are in a *"low risk"* group.

On the basis of the conclusions contained in the report, the members of the Task Force presented a series of eight recommendations, including:

- Health authorities should encourage and support the development of cytological screening programs designed to detect the precursors of clinically invasive carcinoma of the cervix.
- Appropriate means should be employed:

a) to inform women of their degree of risk of developing carcinoma of the cervix;
b) to persuade women at risk to participate in the screening program.

- Frequency of examination should be as follows:

a) initial smears should be obtained from all women over the age of 18 who have had sexual intercourse;
b) if the initial smear is satisfactory, a second smear should be taken within one year;
c) provided the initial 2 smears and all subsequent smears are satisfactory, further smears should be taken at approximately three-year intervals until the age of 35 and thereafter at five-year intervals until the age of 60;
d) women over the age of 60 who have had repeated satisfactory smears may be dropped from a screening program.
e) women who are not high risk should be discouraged from having smears more frequently than is recommended above;
f) women at continuing high-risk should be screened annually.

- All mass screening programs should have follow-up systems to ensure that normal patients are recalled at regular intervals for repeat smears; that action is taken following the discovery of an abnormality; and that long-term follow-up be provided for patients who have received treatment following the diagnosis of an abnormality.

Did you know?

Circulation figures for *The Canadian Nurse* and its French counterpart, *L'infirmière canadienne*, are now close to 128,000 each month. The Canadian Circulations Audit Board Inc., which calculates "qualified circulation" reports that the number of copies of the two official CNA journals distributed in March, 1976, was 127,747. Of these, 90,436 were copies of *The Canadian Nurse*. A year ago, in March 1975, the CCAB reported total circulation of the journals was 113,944 copies. Since March, 1972, when 99,018 persons received the journals, circulation has increased by approximately 28,000 readers. *The Canadian Nurse* now reaches a total of 87,786 persons in this country; of these, 82,698 are Registered Nurses. Almost one-quarter of Canadian readers (21,408) live in the province of Ontario. British Columbia (15,304) and Alberta (13,140) are next largest in size of circulation. *The Canadian Nurse* is received by 1,667 nurses in the United States and 983 nurses in 102 other countries outside of North America. *L'infirmière* is delivered to a total of 36,951 persons in Canada and to 42 other countries.

N.S. hospice unit

A Hospice Care Unit, the third of its kind in Canada, is being planned for the Victoria General Hospital in Halifax. Project originator, Norma Wylie, Associate Professor at the Dalhousie University school of nursing, proposed the hospice as a long-needed unit to care for the terminally ill and their families. The project has been approved by the hospital board, the executive director, the director of nursing service, and senior medical staff.

A "Working Party" Committee is being formed to plan the unit, establish criteria for admission, and provide for education of personnel. The committee is chaired by Wylie, and will include physicians, nurses, clergy, social workers, consumers, and volunteers.

The project evolved from a research project developed by Wylie over the past two years — a demonstration patient care unit known as Project "Back to the Bedside."

Wylie spent some time at the most widely known Hospice, St. Christopher's in London, and has been in correspondence with its founder and medical director, Dr. Cicely Saunders, for advice and assistance.

News





Plumptre visits bargaining officers' conference

Employment relations officers with Beryl Plumptre during spring conference at CNA house. Representatives are: (left to right, back row) Marie Campbell from N.B.; Malcolm Smeaton, Nfld.; Nora Paton, B.C.; Tom Patterson, N.S.; Gertrude Hotte, Que.; Glenna Rowsell, N.B.; and Allan Rosky, Man.; (middle row) Jan Traynor, Professional Institute of the Public Service of Canada; Judy Morry, Nfld.; Joyce Gleason, Man.; Renée Tremblay, Que.; Florence Stemper, Sask.; and Yvonne Chapman, Alta.; (front row) Christine Reynolds, P.E.I.; Anne Gribben, Ont.; Beryl Plumptre; and Mary Parchewsky, Sask.

"The government anti-inflation program is not designed to attack wage earners, nor to roll back the gains hard won by organization, solidarity and tough collective bargaining. On the contrary, it is designed to provide a structure for protecting those gains, and for allowing real wages to keep on growing steadily without being eroded by increasing prices for goods and services." This was the message of Beryl Plumptre, vice-chairman of the Anti-Inflation Board speaking at the spring conference of provincial bargaining officers at CNA house in Ottawa.

In order to clarify the compensation aspect of the anti-inflation program for the representatives of provincial nursing groups, Plumptre outlined the aims of the program and detailed the procedure used to rule on compensations. She explained the three components of the guidelines and then discussed the discretionary powers of the Anti-Inflation Board to take into account special circumstances.

The three general provisions to limit wage increases to between 8 and 12 percent are: the "basic protection factor" which allows pay to increase at the rate of cost-of-living increases as forecast by economic experts, that is, 8 percent in the first year, 6 percent in the second year, and 4 percent in the third year; the "national productivity factor" which gives each working person a share in Canada's long-term productivity growth; and the "experience adjustment factor," an equalizer which the AIB can apply yearly to restrict those groups who leapt ahead before the program was instituted and allow those who were left behind to catch up.

She stressed, however, that the Board was aware that, in some cases, special circumstances must be considered. "The program is not designed to be a cast-iron Procrustean bed that every settlement has to lie in, with the bits that do not fit lopped off or rolled back." To allow for these special cases the Board "has been given considerable discretionary powers to deal with exceptions to the regulations." For example, a group may argue for an increase above the guidelines on the basis of an "historical relationship" between themselves and another group of employees in a similar industry whose salaries have borne a demonstrable relationship in the last two years, and the Board has the power to grant an increase well above the 12 percent. Thus, Ontario public health nurses may supply evidence of an historical relationship with hospital nurses to support a wage increase above the guidelines.

The AIB only deals with settlements, however, it does not enter into negotiations. Tough bargaining may be necessary to get the employer to provide even basic economic protection and, as one representative of the nursing profession pointed out, a clear understanding of the provisions of the program is necessary to avoid being duped by some employers who may choose to hide behind the guidelines at the bargaining table.

When asked what protection the union has that the employer will present a high wage settlement fairly to the AIB, Plumptre stressed that both the union and the employer have an opportunity to make representation to the Board in support of a settlement that exceeds the guidelines.

Plumptre also reviewed the methods of monitoring and restraining prices and emphasized that "the Board means business." She expressed tentative optimism that the rates of price increases are slowing down, with recent statistics showing a rise of 9.1 percent after 20 months of double-digit inflation. She also indicated that, according to price reviews, most industries were restricting themselves voluntarily within the guidelines.

On the pay side, too, she said the vast majority of settlements are within the 12 percent limit. Figures up to the beginning of April show that of 2300 settlements 2150 were within the guidelines.

Finally, she called for the cooperation of all Canadians, regardless of their economic roles, to make the program succeed. The program "is not a price freeze any more than it is a wage or salary freeze. It allows prices to fluctuate as an expression of supply and demand. It allows prices to rise to reflect the real costs of doing business, just as it allows wages and salaries to rise to reflect increases in living costs. What the program is designed to do is bring these increases more closely into line with our rate of growth. Or rather, to help us learn that we can only get more if more is being produced."

Inflation hits Accreditation Council

The number of hospitals surveyed by the Canadian Council on Hospital Accreditation reached a new high in 1975, according to the recently released annual report of the 17-year-old CCHA.

A total of 336 hospitals were visited last year, compared to 294 in 1974. Teams of surveyors reported on 145 of the institutions visited. The report notes that despite the increase in the quality of visits, "quality of work was maintained by improved surveyor education, intensifying team surveys and other means."

The total cost to the CCHA for the survey program and other related activites amounted to $396,152 in 1975. In spite of a fee increase during the year, this cost resulted in a deficit on all operations of $59,738.

During 1975, the CCHA Board determined that the accreditation program was of sufficient value to the Canadian health field that it should be self sustaining and should not be dependent upon grants. Directors authorized substantial increases in fees paid by hospitals per surveyor per day to $475.00 per surveyor day; and in membership fees from $5,000 per seat in 1975 to $6,000 per seat in 1976.

The report notes that "a further increase will be required in 1977 if there is to be reasonable maintenance of quality of CCHA programs and if the required growth to bring more hospitals up to CCHA standards is realized.

'eaching the TV generation – "Multi-Media in Focus"

'hat is self-learning? How can ducators use available tools fectively in teaching and in helping e student learn for himself? Where o we go from here? These questions nd others were explored by 64 ntario nursing educators at a ilization seminar sponsored by the ursing Education Media Project and e Ontario Educational ommunications Authority (OECA) nd held in Toronto on April 23rd.

The theme of the seminar was The Teacher and Tools Together — 'ulti-Media in Focus" and it was imed at examining the meaning of ne term "self-learning," assisting the eacher to develop confidence in the se of self-learning materials, and nhancing teacher creativity. In ddition to providing teachers with the pportunity to discuss their efforts and ommon problems, the seminar itself vas an example of creative learning nd the use of audiovisual materials.

Most of the day was spent in small roups led by nurse-teachers and DECA utilization staff. Participants discussed common aims and experiences and attempted to reach a consensus on what constitutes self-learning, what problems exist in using available resources and developing new ones, and how these problems can be overcome. The morning was devoted to discussion of the learning process and what teachers have to offer their students. In the afternoon excerpts were shown from an OECA film "Don't Cry for David — Part 2" on grieving due to loss of body image. As well as the obvious choice of using this film to complement the study of grieving, team leaders discussed the feasibility of showing excerpts to stimulate discussion of other subjects, e.g. techniques of patient interviewing. Some attention was also given to the use of low-cost audiovisual aids that can be produced easily by the teacher. Team leaders stressed that teachers are teaching the "television generation" and that a wealth of aids exist in this environment ranging from full-length programs relevant to nursing education, to excerpts from serials such as Archie Bunker.

The seminar also provided staff of the Nursing Education Media Project with a chance to assess what nurse-educators need in the way of information and instructional materials. The Nursing Education Media Project was established two years ago to develop films and audiovisual materials for nursing education, to evaluate films and projects prepared by nursing programs in community colleges and universities, and to explore ways of using the media in the college system. It is supported by the 23 member community colleges, the RNAO and the OECA. Membership also includes eight universities, who have been granted observer status, and the College of Nurses of Ontario. For further information about the project, write to Marilynne Seguin, Project Officer, Nursing Education Media Project, Ontario Educational Communications Authority, 4th floor, 2180 Yonge Street, Toronto, Ontario M4S 2C1.

All packed?

The Registered Nurses' Association of Nova Scotia has some last minute suggestions for those who will be attending the Canadian Nurses Association Convention in Halifax in June. With east coast weather by nature unpredictable, the Association suggests being prepared for rain and chilly sea breezes as well as the June sunshine.

If you want to look festive at the Opening Ceremonies or at the Ceilidh at the Chateau Halifax, formal dress is as acceptable as casual clothes. Slacks or jeans are recommended for the trip to Peggy's Cove, and casual clothes for the water tour and dinner at Clipper Cay.

CTRDA nursing fellowship available in 1977

The Canadian Tuberculosis and Respiratory Disease Association is again accepting applications for the $7,500 fellowship the association awards annually for studies in pulmonary nursing. The award is for study at the Master's or post-Master's degree level at a university offering a clinical specialty in pulmonary nursing.

The six universities offering programs acceptable under the conditions of the award are: the University of California at San Francisco, the University of California in Los Angeles; The University of Cincinnati; the University of Arizona; the University of Rochester and the University of Florida.

The first CTRDA Nursing Fellowship was awarded in 1973 to Josette Maranda, Notre Dame Hospital, Montreal. She completed her Master's Degree Course in Clinical Pulmonary Nursing at the University of California in December 1974 and is now working in the RD Home Care Program at the Rosemont Pavilion, l'Hôpital Maisonneuve-Rosemont, Montreal.

Winners of the 1974 Nursing Fellowship were Joanne Perry of Vancouver, B.C. and Pauline Kot of Edmonton, Alta. Perry worked as a nurse clinician prior to completing her course credits at University of B.C. She focused on the educational needs of the patient, the family and the community with emphasis on prevention of illness and rehabilitation of patients suffering from chronic bronchitis and emphysema. She is now a Clinical Specialist at St. Paul's Hospital, Vancouver.

Kot is Associate Professor in Medical-Surgical Nursing at the University of Alberta. Her interests lie in the area of preventive and rehabilitative nursing as well as research. The CTRDA Fellowship allowed her to complete the Master's program at the University of Arizona, School of Nursing, Tucson.

Deadline for applications is February of the current year. Inquiries should be directed to the Chairman, Nurses' Advisory Committee, Canadian Tuberculosis and Respiratory Disease Association, 345 O'Connor Street, Ottawa, K2P 1V9.

How's your image?

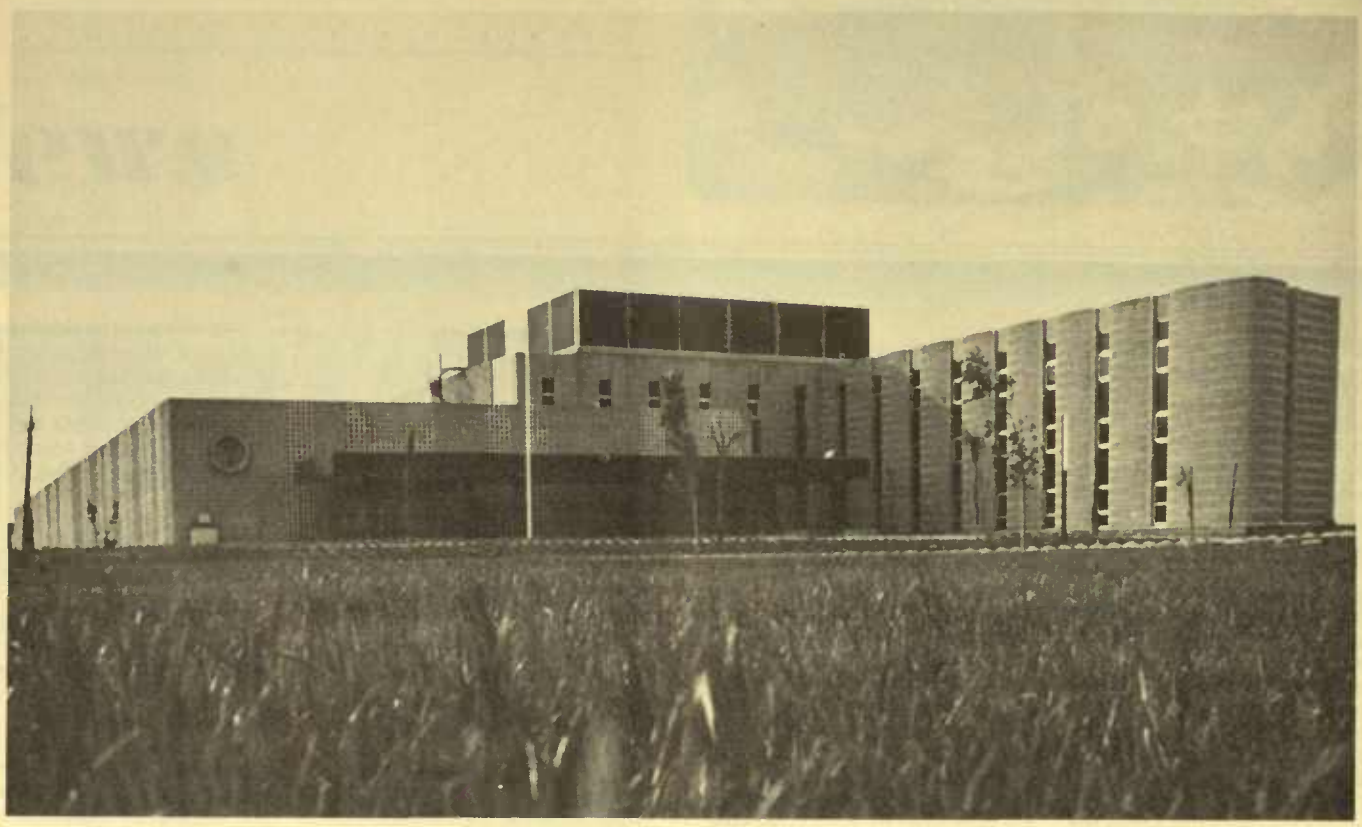
Health promotion is catching on! Following a two-day workshop on fitness and lifestyle at CNA house in Ottawa (See *The Canadian Nurse*, April 1976), representatives from member associations set to work to organize a program with similar content in their home territory. Now, just three months later, most of the workshops have been completed.

After the February training session, each respresentative, with the assistance of Jean Everard, CNA's research officer in charge of fitness, and a grant from Recreatior Canada, was given free rein to set up a program that best suited the needs of their area. The resulting workshops were all aimed at spreading the message of fitness for better health to leaders in the health field, but their focus differed from province to province. While some included key people from many health disciplines (such as physiotherapists, occupational therapists, social workers, dietitians and nurses from VON, public health and hospitals), five provinces concentrated directly on nurses in the public health field, in the hope of reaching the maximum number of people in the community who are in a position to change their lifestyle and improve their health.

The goal of the national fitness program for nurses is to encourage nurses and members of other health disciplines to change their lifestyles to improve their own health so that they become models of *real* health to patients and members of the community.

The word is spreading . . . watch your provincial bulletin for news of fitness programs. Better still, jog to your provincial or chapter headquarters and find out what you can do!

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Authorities estimate that at least 25,000 Canadian women are walking around today with a breast cancer at some stage of growth*. This malignancy will probably not be detected until 1977, 1978, 1979 or even later. The stage at which it is detected, the subsequent quality and length of life of these women, depends, to a great extent, upon the help and support they are able to obtain from health professionals.

BREAST CANCER

da Butler

Breast cancer is a leading killer of Canadian women: figures indicate that one in every fifteen women in this country will develop breast cancer during her lifetime†. At least half of them will eventually die of the disease.

Women can protect themselves by regular self-examination, education, and critical evaluation of the information they receive but it is up to health professionals to motivate and support women in these endeavors. If they are knowledgeable about the critical stages and problems experienced by victims of this disease, nurses can do a great deal to help women who are faced with one of the most agonizing decisions in medicine today.

This help does not require more health personnel, physical or economic resources, but it does involve more effective interpersonal relationships. It requires the helping person to understand the patient and thereby assist that person to problem-solve and move to more effective, higher levels of functioning. Women who develop breast cancer almost inevitably go through similar stages of physical and psychological adjustment. They share certain feelings and problems associated with the disease. Understanding these stages and common responses is important if health professionals are to act as resource persons to the woman and her family. It helps them to see the world through the afflicted woman's eyes and to let her know that this kind of empathy and understanding are available. The role of the health professional is to help the person "get in touch" with her feelings and work them through.

This involves adjustment and movement to a more integrated level of understanding with a different set of priorities at each step. During this process, it is important to remember the rule, "Never presume anything, no matter how little." Find out where the woman is at: validation is an essential aspect of the helping process.

Throughout the eight stages described in this article, the implied intervention is therapeutic use of self, based on open and frank sharing and discussion. The helper must reach out to share the thoughts and feelings of the woman she is helping, without censure or judgment. If she can respond in a sensitive, relevant way, the helping person will find her own life enriched by the experience of sharing small triumphs with her patient at each stage in the progress of the disease.

1. Pre-detection stage

Who are the probable victims of breast cancer? Research indicates that high-risk categories include women who are

- over the age of 40;
- whose menses began before age 16 and continued late in life;
- whose first pregnancy occurred after the age of 30;
- who are obese;
- whose family history shows an incidence of breast cancer, and
- who belong to upper socioeconomic groups.[1]

Since experience has shown that the survival rate is directly related to the stage at which the tumor is found and treated, early detection and treatment are essential if more lives are to be saved. One of the main barriers to detection is *denial*. Our society, as it reveals itself in the media, is fascinated with full, abundant breasts. Breasts are regarded as functional, aesthetic, and symbolic. The self-image of many women is tied to her feelings about her breasts. When she contemplates the possibility of breast surgery, she feels her personal identity is threatened. The "I can't bear to think about it" and "It can't happen to *me*" syndrome often leads to avoidance of practical, easy methods of early detection available today. Denial plus increased anxiety may also exist if breasts are lumpy due to fibrocystic disease. Management and follow-up programs are particularly important in these cases since statistics show findings of breast cancer in six percent of women operated on for fibrocystic disease.

Women *can* be helped to work through the feelings that act as barriers to early detection of breast cancer. Many useful and interesting books have been published recently on the subject, including Rose Kushner's "Breast Cancer." The Canadian Cancer Society provides brochures and other materials, including pamphlets, explaining the procedure used in breast self-examination. There is no scarcity of information from the various media, but, in order to assimilate and apply it, most women need professional support and assistance. For example, in spite of national advertising campaigns intended to publicize the importance of self-examination of the breasts, it is estimated that fewer than 38 percent of Canadian women perform regular breast self-examinations. This simple procedure which should be carried out every month should be taught in a matter-of-fact manner to all girls in their early teens. If this were done, much of the emotional overlay

1. Mastectomy rehabilitation programs are now available in many Canadian centers to provide both pre-op and post-op support and counsel for breast cancer patients. The programs are staffed by volunteers who have personal knowledge of the operation and operate under the auspices of provincial divisions of the Canadian Cancer Society.

Below, volunteer Vera Myers, a member of the Rehabilitation Recovery team in Ottawa, demonstrates the "Play Ball" exercise using a rubber ball on a length of elastic.



Photos by Dominion Wide Photographs Ltd.

associated with the procedure could be avoided or dissipated and the examination would become an accepted "fact of life."

2. Suspicion

Most breast lumps are found by the woman involved, who then asks herself, "What shall I do?" Often, there is a period of delay before professional help is sought. This stage may be short or long. The woman who usually copes well with stress will probably seek immediate medical attention. Other women say, "I'll go right after my daughter's wedding," or "as soon as the kids are back in school." There may be magical thinking, "If I don't look, it will go away."

What contributes to delay? Only a small percentage of palpable breast lumps prove to be malignant. Therefore, most women with breast lumps will receive good news after checkup. However, many women still regard finding a lump as the beginning of the end.

A significant number of women lack knowledge about breast cancer and the importance of early diagnosis and treatment. They do not know that a lump or thickening of the breast is a warning signal. Less common signals are also unknown to many women. These include:

- puckering or dimpling of the breast skin;
- scabbing skin around the nipple, changes in skin texture, cracked nipples, or secretion from the nipple;
- asymmetry in either appearance or movement of the breast;
- hot, swollen or sore breast. Any unusual ache or pain that is persistent and not associated with cylical changes.

The fearful woman may become completely disorganized and unable to function after finding a breast lump. She may delay seeking help. Some women say, "I couldn't tell anyone" or "I didn't want my husband to know."

Husbands and families are important. One woman recalled, "My husband ignored the lump. He put me down, told me to forget it and it would go away. I ignored it for two years." In contrast, many women are able to share fears and concerns with family, friends and health professionals. *Open and honest communication is one of the keys to dealing with this kind of stress and fear of the unknown.*

3. Medical evaluation

The evaluation period invokes stress responses that differ according to the experiences, beliefs, attitudes and cultural values of the individual. The stoical woman says, "It will be O.K." The fatalistic woman says, "My life is in the hands of the gods." There may be displacement of feelings, "I'm only worrying about my family." Projection of feelings is associated with fear and despair, "I'm just a guinea pig." All women need help in explaining and examining their feelings, adaptive and maladaptive.

If the lump is found to be malignant, the woman has a choice: to accept both diagnosis and treatment, or to reject one or both. She may choose, as is her right, to seek additional professional opinions. *Scrupulous honesty, preservation of hope, frank discussion of outcomes and involvement of family members or friends are essential if she is to pursue treatment and become closely aligned with a supportive health care delivery system. She needs caring people to share her hurt and pain and to endure with her over time.*

Decisions about treatment involve facts but are based on much more than just facts. Under stress, many people do not hear, remember or process the information that can enable them to make meaningful decisions. The woman who has been told she has breast cancer needs a caring person to help her perceive and deal with the facts.

More and more women are showing a desire to become involved in decision-making processes regarding medical treatment. In some centers, biopsy is done on an outpatient basis. A woman can then discuss treatment plans with her husband, family and physician while remaining in the comforting, familiar home atmosphere. The trauma of breast surgery is less of a shock for women who remain at home for even a few days before surgery. This brief time permits anticipatory psychological work in terms of the grieving process and also allows time for the staging and testing procedures which are so important at this stage. These procedures determine the extent of the disease and the feasibility of surgery.

In recent years, there has been widespread debate and controversy over the surgical procedures which offer the best chance for long-term survival. Quality of life also enters into consideration at this stage. For some, radical mastectomy seems "worse than death." Most women, however, weigh the risk-reward ratio and decide to have surgery. This attitude is sometimes expressed in the statement that, "I'd give up my breast in order to save my life."

Seven surgical procedures are available

and 3. The "Pulley Motion" is other of the exercises patients can arn while still in hospital. Here, lunteer Myers improvises by using an IV pole instead of a door to demonstrate the principle of the seesaw motion involved in this exercise.





From least to most extensive, these are 1) lumpectomy, tylectomy, and local excision, 2) partial mastectomy, segmental resection, and wedge resection, 3) simple (or total) mastectomy, 4) modified radical mastectomy, 5) halsted radical mastectomy, 6) supraradical mastectomy or extended radical mastectomy and 7) subcutaneous mastectomy.

Some of these procedures allow for the possibility of future reconstructive surgery. The latter should be discussed with the surgeon preoperatively. At present, restorative surgery is available to only a few women but there is hope for the future, especially if many women are concerned enough to press for breast reconstruction.

4. Response to diagnosis

A woman's response to the diagnosis of breast cancer follows a clearly identifiable pattern, colored by her post-conditioning. The feelings of a woman whose mother is alive and well 17 years after surgery will be quite different, for example, from those of one whose older sister died after a lingering illness.

Nevertheless, everyone dies a little on diagnosis. Feelings of denial, anger, depression and fear are common. The woman may also feel abnormal, "in an unreal space." She needs to be reassured that this is normal so she does not think that she is alone and unable to share "unnatural" emotions. These feelings are cyclical in nature, recurring from time to time over many months. The woman must work through her feelings in order to deal effectively with her loss. The person who is secure in the feeling that she is loved and respected for herself is often able to adjust more quickly. It is harder for the person who feels valued for appearance, physical ability and capacity to work.

A frightened woman was recently hospitalized and booked for breast surgery. Her husband visited her the evening before surgery. They talked, and he said "The advice you have given me over the years has meant so much to me. You are so important to me." The woman told the evening nurse that her husband had helped her to view things in a different way and she felt much relieved and less fearful.

5. Reactions to breast surgery

Shock and Disbelief. After diagnosis there may be a short period of denial, quickly followed by feelings of shock and disbelief. Women say, "I can't believe this is happening," and "I can't think." Husbands, children and friends share these feelings. One man told his wife's physician that on learning her diagnosis he left the office profoundly upset. This feeling was followed by total loss of memory for the events of that particular day.

Fear. This is the most pronounced feeling. The woman not only mourns the loss of her breast but also experiences anticipatory grief in relation to loss of her life. Both husband and wife have a strong realization of death. Often they are not able to discuss this with anyone, even each other, *open communication and acknowledgement of feelings helps both partners learn to face and cope with fear.* A middle-aged man with two daughters recalled, "my greatest fear was that my wife would die during surgery. I prepared for the worst. I needed help but was ashamed to ask for it. Everyone seemed so busy. On some days this feeling still lives within me." The wife of this man had breast surgery three years ago.

A woman with young children thinks, "What will happen to my children if I die?" She may need help in delegating her life tasks, at least temporarily, to a competent person who understands and respects her feelings and concerns. It is essential that she feel certain that her children are safe and well. She also needs to know that her family love her, need her and miss her unique kind of loving care.

Children fear that their mother will die. They cannot help but feel the upheaval in family life style, and the anxieties and fears of their parents. Information should be given to children at their level of ability to comprehend; withholding information causes anxiety and resentment. Later, the child may be very angry that he or she was not allowed to participate in the family crisis. A ten year old can feel the lump in her mother's breast and realize that it should not be there. This preparation makes the surgical procedure easier for the child to understand.

Teenage daughters can be very helpful and supportive if they are allowed to share with the mother in her loss. Teenage sons may have a difficult time during the crisis. A son may refuse to visit his mother or talk about her illness. He may refuse to tell anyone outside the family. It may be helpful to his mother to know that this kind of reaction is not uncommon. Sometimes it is useful for a boy in this position to talk to the son of a woman who has made a successful adjustment following breast surgery just as his mother may find consolation in talking to another mother whose son, at one time, behaved in a similar way. *Perceptive health professionals can help*

4. "Rope Turning" is an exercise that can speed the mastectomy patient's return to a normal way of life. The equipment in this, as in the other exercises, is simple and easy to obtain. Patients must obtain the approval of their doctor before beginning the program.



facilitate such valuable learning opportunities.

Anger and Depression. Many women are overwhelmed by feelings of hopelessness and helplessness after breast surgery, followed by feelings of anger which may find one or several targets. The woman may be furious at her surgeon, at God, at society or at organized religion. She many say, "Why me," especially if her life style has been exemplary. A well-established older couple may say, "Why us? We can only just now afford to enjoy and relish our lives." It is healthy and cathartic to express feelings of anger, even if they come out as blind, diffuse fury. Problem-solving is difficult when strong feelings of anger are repressed.

A mastectomy patient recently said:

I didn't know what was the matter with me, I just felt miserable. One morning the head nurse came and sat down close to me. She said she felt I was very angry. I soon realized that she had hit he nail right on the head. I spent the next half hour telling her how much I hated everyone and everything, and how awful everyone was to me. That was the beginning of my recovery. I never looked back. She who was my worst enemy became my dear helping friend.

Venting of anger may avert the severe depression which sometimes follows breast surgery. Some degree of depression is normal and occurs on an intermittent basis for a long time. Many husbands share this feeling which is associated with grief and mourning.

Guilt. Feelings of shame or guilt are sometimes present. The woman relates her loss to a personal flaw or wrongdoing and reviews the "precipitating event" again and again. She may say, "I was careless and hurt myself or, "If only I had not ...." It is as though the disease appears so irrational that the self must be blamed.

It is important for the helping person to recognize that such a woman is experiencing feelings of shame or guilt. *She should be encouraged to talk about her feelings and to try to determine the reason for them.* In what way does she feel inadequate, humiliated or a failure? In what ways does she fall short of her ideal? How did she acquire these expectations? Are they still appropriate? What does she want to do?

6. Crisis following surgery

A year following her mastectomy a woman confided to a friend, "At first I felt mutilated and mangled. Someone told me I ought to be able to go home and carry on as though nothing had happened. This made me feel worse." She went on to say:

Nearly everyone on the ward was comforting and helpful to me. During the first week, I was encouraged to look at my scar. I did, and it finally hit me that my breast was gone. I cried, talked about it, and gradually got myself together. A few days later I wanted my husband to see the scar too, so he would know what I knew. This was hard, but he managed O.K. After that he sat and held my hand for a long time. We sort of went through it together. He's been wonderful.

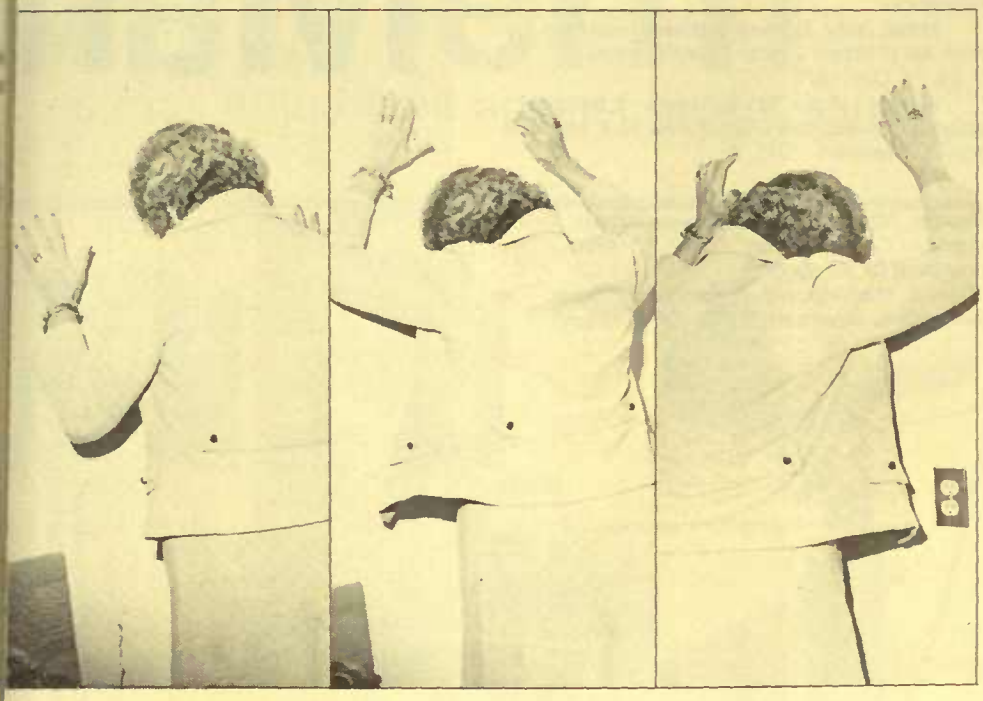
Breast surgery DOES make a difference: support people are very important. A husband can be a pillar of strength if he is included and not rejected or encouraged to withdraw. With the help and encouragement of understanding health professionals, other family members — sisters, mothers and daughters — can also be key support people. Through them the woman gradually regains her image of herself as a person who is loved and who cares for others.

Volunteer Visitors. Throughout Canada, volunteers from the Mastectomy Rehabilitation Programme offer practical help to women facing breast surgery. They are women who have undergone breast surgery and can act as a role model. They are prepared to visit pre- and postoperatively at the request of the physician. They provide a lightweight temporary prosthesis and can offer expert advice on permanent weighted prostheses. Sponsored by the Canadian Cancer Society, these volunteers present a realistic picture of adjustment to the woman as the works to resolve her feelings following surgery.

Health Teaching. After radical mastectomy it is vital to begin exercising immediately, to strengthen the auxiliary muscles of the arm that take over for the removed pectorals. This is also important after a modified radical, even though the chest muscles are intact. In addition to arm exercises, breathing and relaxing exercises should be routinely taught as one method of tension relief. The woman needs assistance in commencing and carrying out these exercises.

Patient teaching is extremely important and should be reinforced at intervals since, initially, some people do not hear or understand. The woman should be warned that the afflicted arm must never be used for taking blood pressure readings, for immunization, vaccination or injections of any kind. Shaving under the arm is a "no-no" when

6. and 7. "Wall Climbing" is an exercise that gets a little easier every one, according to volunteer Myers who advises patients to "try to climb a little higher up the wall each day. Soon your arms will be straight over your head."



eeling is absent. She should also be cautioned about oral contraceptives because of their possible role in the nourishment of breast cancer. Breast self-examination should be retaught. The monthly BSE should now include careful palpation of the area around the incision. Recurrence sometime appears in the incisional site itself. Women with breast cancer must always be on guard for symptoms.

Follow-up care should be discussed. This usually includes quarterly examinations during the first two years followed by semi-annual examinations. Blood work and X-rays are usually included. The informed consumer finds and remains in contact with a physician whom she trusts.

7. Early months at home

Going home brings the woman face to face with several questions. "What should I tell my family, my friends? Am I different? Do other people see me as being different?" There is a good deal of testing and experimenting with the environment through communication. "Is it noticeable?" "Do you think people will know which side?" Self concept is built up gradually and functions in relationship with other people.

The woman should purchase a 'permanent' breast form several weeks to a month or so after surgery. Before doing so, she should check to see whether her medical plan carries an extended benefit which helps pay for prostheses. Some women feel that hospitals or community health centers should make forms available for display and for purchase at cost. She should find the nearest center with a surgical or mastectomy fitter, phone for an appointment and not buy until she is completely satisfied with both appearance and comfort.

In answer to the question "Will I ever get over this feeling of incompleteness?" The answer is "Yes, by talking and being with people, over time." This does not mean that the person will view her body change as good, but she will accept it, and see it as a "fact of life." With the resolution of some of the strong feelings related to her surgery, the woman is able to gear herself for the tasks which lie ahead.

Additional Treatment. For some women there is no period of health following surgery. The woman must immediately come to grips with the fact that the disease still exists and lives within her. Further treatment is necessary when surgery has not stopped the disease or when many positive nodes are present in the axilla. In some centers, chemotherapy has become the first treatment offered after surgery. Because this era of experimental therapy is just dawning, every drug now known to be effective against cancer has some possible side effects. Further surgery such as ovariectomy and adrenalectomy may offer methods of endocrine manipulation. Radiation may be used to manage palliation of symptoms to improve the quality of the person's life. Immunotherapy, still in the experimental stage, may represent another arm to the therapeutic program.

Much more than emotional first aid is required if the woman is to keep in touch and work through her feelings during this time. Communication should be open, with discussion and decision-making concerning treatment jointly involving the woman, her family and concerned health professionals.

Ambiguity or uncertainty about any aspect of diagnosis and treatment is intolerable. Many women report that their greatest frustration is receiving one message verbally and another message nonverbally from people around them. "I knew that I wasn't getting the straight goods" and "I saw a different doctor every time and was never told anything much" are common complaints. Women need to be educated about their right to informed consent. They should be given support in their desire to be treated as equal partners with members of the health care team.

Women wish to be treated as mature, intelligent adults. One successful business woman with terminal cancer recently stated, "I was more or less told that I should be a good girl, go home and let someone else worry about it." According to another woman:

> *"I was managing my household and working part time. Yet whenever I went for a checkup, I donned a hospital gown and was wheeled into the room on a stretcher and examined lying down. People talked about me as though I wasn't there. When it was all over, I was wheeled out."*

8. The next ten years

The five year survival period formerly applied to all cancers is no longer considered valid for mammary carcinoma. According to Kushner:

> *Breast cancer is a chronic disease, just as diabetes is a chronic disease ... We can relax and breathe easier after two years — the period where more than half of the recurrences and metastases first show up. And we can breathe even more*

deeply after five years. But the definite time for measuring breast-cancer survival is now ten years.[3] Obviously, women must be on guard for ten years: it would be cruel to suggest otherwise because this could result in unnecessary deaths.

Conclusion

Confusion, controversy and misunderstanding still surround our present state of knowledge about breast cancer. Research into the causes of the disease and modalities of treatment continues around the world and could, it is hoped, produce a major breakthrough any day.

In the meantime, there is a great deal that nurses, working closely and constructively with their women patients, can do to combat the apprehension and pessimism that colors our thinking about this disease. Early detection and prompt treatment are still the best methods of reducing mortality. If a mammary carcinoma is detected when it is still less than one centimeter in diameter, there is a 90 to 95 percent chance that it has not metastasized. By the time it reaches four centimeters, the probability that it will be confined to the breast is reduced to about 60 percent.

Obviously, public education is a key factor affecting survival and nurses are in an ideal position to accomplish this important function.

Nurses also encounter many women who have reason to suspect that they have breast cancer or who have been diagnosed as having breast cancer. When this happens, they have a unique opportunity to respond with the understanding and support that these women need.

Ada Butler (B.A.Sc., M.S.N. University of British Columbia), is assistant professor with the U.B.C. school of nursing in Vancouver. *This article, which demonstrates her special awareness and sensitivity to the critical stages and common problems faced by a woman with breast cancer, is based on more than a year of systematic data gathering. The author reports that, in order to gather the information contained in the article, she searched the literature, conferred with health professionals in many disciplines, and interviewed and worked with many women patients with breast cancer.*

Photos courtesy of the Ottawa unit of the Ontario Division, Canadian Cancer Society.

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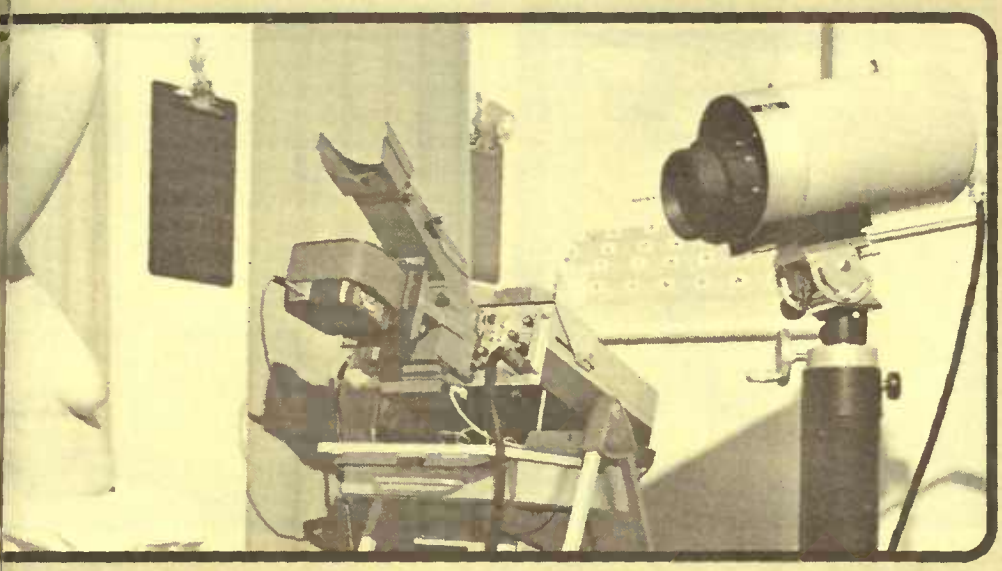
Mam

Thermography in progress
Patient positioned for thermography. *Center:* Viewer and polaroid camera attached to operating console with monitor screen below. *Right:* adjustable

Detection centers are an important aspect of the North American program to promote earlier diagnosis and treatment of breast cancer. One such Canadian center is the Thermography Unit of the Royal Victoria Hospital in Montreal. Monica Bacon, who is the nurse in charge of this unit, describes mammatherm,[1] the breast thermography technique in use there.

mmatherm

a weapon in the fight against breast cancer



Monica Bacon

Early detection continues to be the cornerstone on which the Canadian Cancer Society rests its claim that cancer can be beaten. At the present time, detection approaches used in the discovery of breast cancer include physical assessment, radiological examination (mammography), thermography (mammatherm) and, if indicated, breast biopsy. Of these, only breast biopsy is considered a proven method of diagnosis but each of the other techniques offers the consumer certain advantages and, together, they now provide women with the only known way of reducing the death toll from this disease. Although most nurses, and many consumers, are aware of the detection techniques and principles involved in breast self-examination and mammography, many are not yet familiar with the use of another screening procedure — *thermography — a heat detection technique that locates warmer tissue in the breasts.*

What is thermography?

Thermography is, essentially, a scanning technique used to detect infrared heat. It has come to play an important role in many scientific fields, including medicine, where its possible uses are numerous. Probably the most widely known and recognized of these uses relates to the area of breast tumor screening.

A mammatherm is a picture of the surface of the breasts using infrared scanning to detect and indicate thermal activity (physiologic function) below the skin by the coinciding emission of heat. This produces a "hot and cold" pattern on the picture showing areas of increased and decreased heat generation. Interpretation of these pictures serves to alert the doctor to possible abnormalities below the skin requiring further investigation.

Since breast tumors are known to generate large amounts of heat and to alter vascular[2] patterns, especially during the early stages of mitosis, thermograms can assist the doctor in breast examinations. Repeated annually, they may also serve to detect otherwise unremarkable functional changes. All women, regardless of breast size, age, medical history or family background, could (and perhaps should) be candidates for breast thermography. It should be noted however that accuracy appears decreased during the menstrual phase of the patient's cycle due to vascular engorgement and ductal changes at that time.[3]

Procedure

The procedure is painless, simple, quick and harmless. The patient disrobes to the waist and waits approximately ten minutes in a "cooling" area with arms held away from the body. Generally the cooling area is maintained at a temperature of 68°F (20°C) and is kept free of drafts and interfering warmth (such as sunlight). This encourages more accurate adjustment of the body surface temperature and promotes individual infrared heat emission. During the mammatherm the patient is positioned with chest erect and arms elevated. Pictures are taken frontally and laterally.

Technique: untrained, inexperienced or careless operators of thermographic equipment can lead to faulty procedures and poor quality pictures.

Primarily, the focusing must establish a well-defined image avoiding shadows and unrelated sources of temperature interference. Ranges of gray leading to extremes of black and white represent the temperature scale. Of this, the middle gray is considered the "middle temperature" and is individually established after clarification of the image. The axillae, stemum and/or inframammary folds are usually warmer by approximately 2°C than the average normal breast tissue.

The pictures should illustrate contrasts between areas which are "hotter," "colder," or "equal to" the background or middle temperature by the black-gray-white pattern.

Opinions vary regarding the use of black or white as an indication of increased heat but, either way, the areas emitting infrared heat become obvious.[4] Differences are also found in the choice of apparatus and film. But again, the basic purpose of discovering possible abnormalities is the prime objective, with the degree of efficiency as well as expense also a consideration.

Interpretation: Accurate interpretation of mammatherms also depends upon a high degree of training, experience and competence. If this is lacking, even the best quality pictures can be misread and important features overlooked.

The initial assessment requires an overall view of all pictures in search of areas illustrated as warmer than the recorded middle

Mammatherms

Illustrations are frontal pictures from a series of five (frontal and lateral) for each patient. Interpretations based on entire series.

Fig. 1: 43 years old.
Normal warm breasts.
Symmetrical hypervascularity



Fig. 2: 50 years old.
Normal cold breasts.
Symmetrical sparse vascularity.

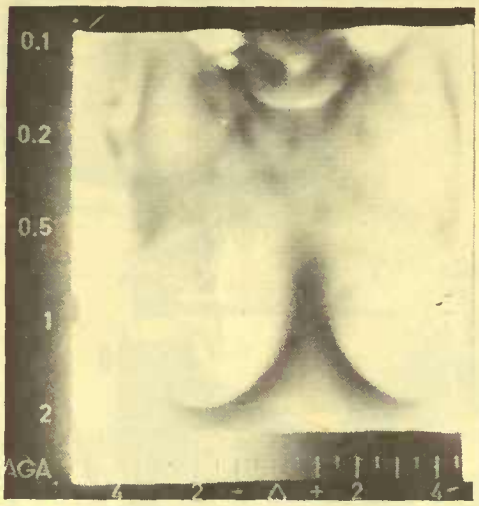
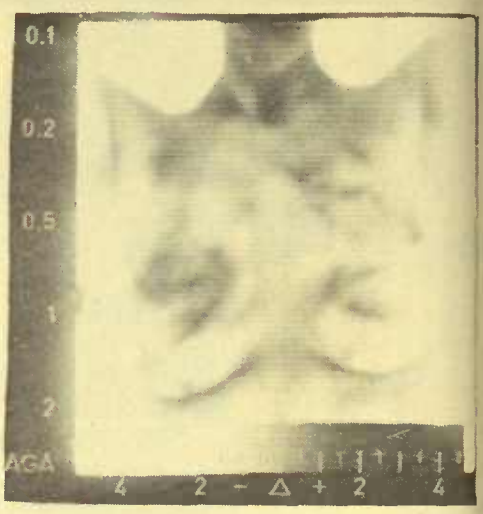


Fig. 3: 57 years old.
Suspicious increase in temperature and vascularity in right breast with coinciding increased areaolar temperature.



temperature. This enables observations to be made regarding the temperature and vascular patterns of the breasts. Whether superficial or deep, the vascular pattern shows itself as somewhat warmer than breast tissue and can usually be considered sparse, normal or hypervascular. Similarly the breast tissue may appear completely cool (fatty) or warm (dense) but rarely hot throughout. Using the middle temperature level as a baseline, comparative recordings are made of the locations and temperatures of any "hot spots" thus exposing an asymmetric pattern indicative of abnormalities. Asymmetry in the number, temperature and/or caliber of the vascular patterns also equires notation. The nipples and areolae are usually the coolest aspects. It may also prove helpful to record the temperature difference between the hottest and coldest readings in each breast. Irregularities such as size differences, deviated contours, or nipple inversions, which may prove pertinent to the overall breast examination, are also noted at this time.

Value: As indicated, mammatherm is not in itself a means of diagnosis. Rather, it is a method of assisting the doctor in completing a diagnosis as well as an annual check for indications of changes within the breasts. The question remains as to the degree of dependable assistance it provides and what eventual diagnostic uses it may offer. Theoretical answers are numerous and varied. Two of the most common are:

- Mammatherm is of value *only when performed in complementary conjunction with thorough clinical examination and mammography (breast x-ray).*[5] In this case further investigation and treatment are instituted mainly on the basis of reported positive findings from the other two checks, although a positive mammatherm is considered supportive.
- *A combination of positive mammatherm and clinical examination is sufficient basis for investigation.*[6] Mammography is recommended but its questionable or near-normal report does not deter the investigation.

Patient histories

Patient A: A 32-year-old woman, with no previous history of manifestations of cancer but whose mother had had the disease, found tenderness in her right breast. Her gynecologist referred her to our clinic for a thermogram, which revealed an area of suspicious warmth in the upper quadrant of her right breast. She then had a mammogram that indicated density in both breasts, with scattered calcifications in the right breast, and a benign nodule in the left. The patient went on to have a biopsy. Results disclosed the presence of infiltrating duct cancer in the right breast. She underwent a radical mastectomy, and is doing well nine months after surgery.

Patient B: A 50-year-old woman complained to her doctor of a lump in her left breast. There was no family history of cancer, nor had she herself had any other symptoms of the disease. On being referred to our clinic, she had a thermogram which showed increased heat and vascularity in the upper outer quadrant of her breast.

Because malignancy was suspected, further testing was recommended. A mammogram revealed only dysplasia and a possibly benign nodule. However, the patient went on to have a biopsy, which gave evidence of infiltrating duct cancer of the left breast. She then had a modified radical mastectomy. A year later, she is still well.

In this patient's case, the mammogram gave no definitive proof of the heat activity in her system that had been apparent on the thermogram.

g. 4: 60 years old.
uspicious increase in
asculanty of left breast,
ith coinciding increase in
mperature of nipple.

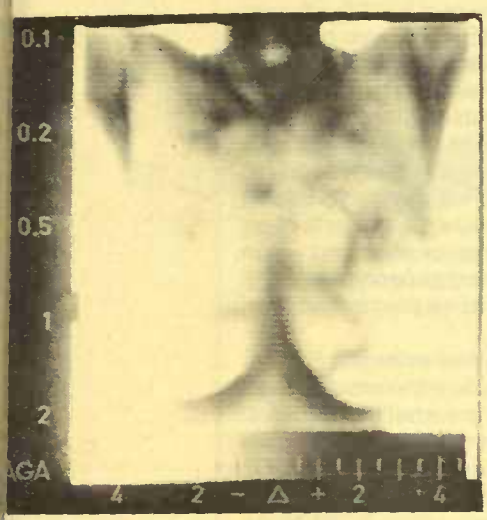
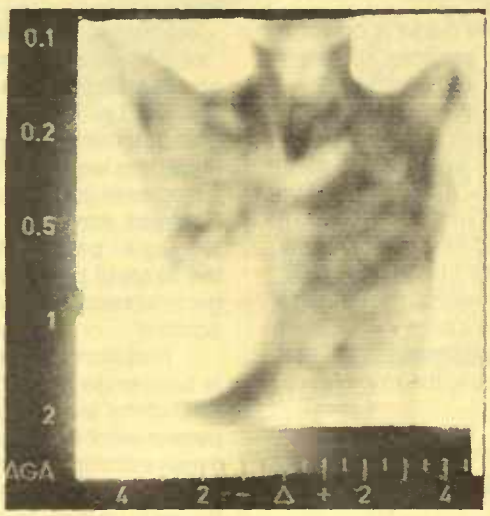


Fig. 5: 60 years old, post-mastectomy. Slight increase in temperature of right upper outer quadrant. (Mastopathy later clinically diagnosed).



Conclusion

It is impossible, at present, to declare a definite proven protocol for diagnosis of breast cancer. *Mammography*, since it is an x-ray technique and causes exposure to radiation, cannot be performed repeatedly over short periods of time, nor on certain individuals. It is, however, a proven diagnostic tool, although producing occasional "false negative" reports. *Thermography* is harmless and simple but it is not considered diagnostic and more likely to indicate "false positive" findings. It is obvious that clinical examination is necessary and a tissue biopsy is still the only definite and proven means of diagnosis of carcinoma of the breast.

Monica Bacon, R.N.,(Royal Victoria Hospital school of nursing, Montreal), received her training as thermography technician and interpreter at Jefferson Medical College Breast Diagnostic Center, Philadelphia. She is the nurse in charge of the Thermography Unit at the Royal Victoria Hospital . She is a member of the American Thermographic Society, as well as an active member of the Board of Directors of the Royal Victoria Hospital Nurses' Alumnae Association. Her nursing career has included practise in the areas of hemodialysis, endocrine research and a community health clinic.

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Note: A bibliography is also available on request.

ACTIFED*
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Indicotions: The prophylaxis and treatment of symptoms associated with the common cold, acute and subacute sinusitis, acute eustachian salpingitis, serous otitis media with eustochian tube congestion, aerotitis media, croup and similar lower respiratory tract diseases; in allergic conditions which respond to antihistamines including hay fever, pollenosis, allergic and vasomotor rhinitis, allergic asthma.

Precautions: Use with caution in hypertensive patients and in patients receiving MAO inhibitors. Patients should be cautioned not to operate vehicles or hazardous machinery until their response to the drug has been determined. Since the depressant effects of antihistamines are additive to those of other drugs affecting the central nervous system, patients should be cautioned against drinking alcoholic beverages or taking hypnotics, sedatives, psychotherapeutic agents or other drugs with CNS depressant effects during antihistaminic therapy. Rarely, prolonged therapy with antihistamines can produce blood dyscrasias.

Adverse Effects: None serious. Some patients may exhibit mild sedation or mild stimulation.

Dosage: Adults & children over 6 years, 2 teaspoonfuls of syrup or 1 tablet 3 times daily. Children 4 months to 6 years, 1/2 adult dose. Infants up to 4 months, 1/2 teaspoonful of syrup 3 times daily.

Supplied: Syrup, Tablets: Each white, biconvex tablet 7.4 mm in diameter with code number WELLCOME M2A on same side as diagonal score mark or each 10 ml of clear, lemon-yellow syrup contains triprolidine HCl 2.5 mg and pseudoephedrine HCl 60 mg.

The syrup is available in 115, 225 and 2250 ml bottles; tablets are available in packages of 12 and 24, and bottles of 100 and 500.

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The ICN Code of Ethics states that the need for nursing care is universal, and is not restricted by race, color, creed, sex, etc. Yet prejudice *does* exist in nursing and may even be fostered by the social structure of most hospitals. The author explores the effects prejudice can have on the nurse's ability to help her patients, and suggests approaches for reducing prejudice.

PREJUDICE in nursing

Nora J. Briant

The traditional image of the nurse is one of a warm, caring person who provides *all* her patients with the physical and emotional support they need. Since many of us who entered the nursing profession did so with a genuine desire to help, we work hard to meet this ideal. Still, there are few nurses who have not encountered situations where they found it difficult to care for a particular patient. Many will admit that this difficulty stems from their own feelings or attitudes towards the patient's problem. How many more cases exist where "prejudice" goes unnoticed in ourselves and yet proves to be an obstacle to the kind of care we want to give?

Table 1

Question: *Have you found it difficult to give optimal care to any of the following?*

	Female nurses replied yes	Male nurses replied yes
Drug addicts	41%	40%
Alcoholics	34%	29%
Homosexuals	29%	21%
Criminals	25%	16%
Attempted suicides	21%	16%
Very old persons	16%	21%
Welfare patients	7%	11%
Minority group members	3%	7%

(from: "Nursing Ethics: A Survey Report", *Nursing '74* September 1974, pp. 35-44.)

What is prejudice?

Prejudice is a universal phenomenon; it occurs in society as a whole and in individuals. The word is most often used to mean hostile attitudes towards racial or other groups,[1] but there is a larger meaning than is generally intended in conversation. Sociologist, David Popenoe, says that "prejudice consists of judging — people, things, or situations — on the basis of preconceived stereotypes or generalizations. A prejudice may be either positive ... or negative..."[2]

Prejudices are learned attitudes. No one is born prejudiced. Social experiences from the time of birth determine what prejudices a person will have. Discrimination occurs when these attitudes are reflected in action.

To understand prejudice further, it must be realized that "in many cases it can be a necessary condition for social interaction."[3] A stockpile of previous experiences allows a nurse to make many prejudgments throughout the day. She or he may assume that the dietary department will provide meals, that a porter will help carry heavy objects when asked, and that when she or he says "How are you?" to co-workers in the hall they will reply "fine thanks," but patients may not. It would be socially exhausting if a person could never make decisions founded on a preconceived idea. It is important to be able to make generalizations based on stereotypes. This kind of prejudice is not the problem. "Rather it is the failure to discard a prejudgment in the light of additional evidence,"[4] or the failure to seek out evidence contrary to the prejudgment.

Prejudice is not limited to race or ethnic origin. Any characteristic a person may have can count as a mark against them in someone else's book. Some common targets of prejudice in nurses are alcoholics, "hypochondriacs," dying patients, doctors, obese people, and homosexuals.

Effects of Prejudice

What is the official stand taken by the nursing profession with regard to prejudice? The International Council of Nurses Code of Ethics reads, "The need for nursing is universal...It is unrestricted by considerations

of nationality, race, creed, color, age, sex, politics, or social status."[5]

Are the words and the deeds of nurses consistent? Evidence indicates that they are not. Surveys have found that many nurses are indeed prejudiced and that their attitudes can affect their ability to provide care.

1 *The nurse will not give optimal individual care:* It is difficult to measure good care or bad care and even more difficult to cite definitely the cause of it. A survey done recently[6] links prejudiced attitudes to quality of care by inquiring into the feelings of nurses. The question posed was, "Have you found it difficult to give optimal care to any of the following?" and eight groups of patients were listed. The responses of more than 11,000 nurses are summarized in Table 1. A large number of respondents admit that prejudice is affecting the quality of care they give.

2 *Problems may be overlooked or misinterpreted:* This can be effectively illustrated by part of a study done on "Value differences between nurses and low-income families."[7] Nurses were asked to grade a list of statements once according to their own values and once according to the way they thought low-income families would respond (see Tables 2 and 3). It is interesting to see how similar the nurses' values were to those of the low-income mothers. Yet the difference between the mothers' values and the nurses' perception of the mothers' values indicates how little the nurses understood their patients.

The sample for this study was drawn from the roster of a maternal and infant care program which was troubled with poor attendance. It is possible that these nurses considered the mothers' values to be an important factor in nonattendance. The evidence does not support this view, however, and shows how easily behavior can be misinterpreted. As this case demonstrates, the *real* causes of a problem may be overlooked because of prejudice.

3 *Prejudice spreads by labeling:* R.M. Davidites says that labeling is often caused by role conflict.[8] "Members of the medical team — doctors, nurses, social workers, and ancillary personnel — have specific role expectations of themselves as well as for patients...Patients who do not meet the role expectations of the medical team create a state of disequilibrium."[9] She suggests that one of the coping mechanisms frequently used by hospital staff is to label the patient abnormal and request a psychiatric consultation. "Thus the problem is defined as existing within the patient."[10] It is not acknowledged that the problem could be within the staff or within the system which causes the roles to be in conflict. As a member of a psychiatric consulting team, Davidites noted that patients who act abnormally but do *not* disrupt the social order are not labeled. No psychiatric consultation is requested. As long as they do not cause conflict patients are not considered to be mentally ill.

A patient who has been labeled is much more likely to be treated in a stereotyped manner[11] with little or no consideration given to individual characteristics, needs or problems. This will not only affect future associations but may also affect the interpretation of past behavior. For example, if someone is labeled "hysterical," their past legitimate calls for help will be seen in retrospect as unnecessary and hysterical. »

Table 2

Percentage *of nurses, nurses' perceptions of families, and mothers' responses to health statements as important* **(I)**, *somewhat important* **(S)**, *or unimportant* **(U)**

Health statements:

1. My family and I should have immunizations.
2. I should follow the doctor's advice in raising my children.
3. I should know about many home remedies to use when my family is sick.
4. I should take the child to the doctor whenever he is sick.
5. I should have a yearly physical examination.
6. I should expose my children to childhood diseases early.
7. I count on luck to help me stay well.

Statement	Nurses' response			Nurses' perception			Mothers' response		
	I	S	U	I	S	U	I	S	U
1.	100	0	0	10	85	5	95	5	0
2.	52	48	0	5	82	13	50	25	25
3.	14	56	30	73	17	10	65	20	15
4.	60	40	0	22	73	5	65	30	5
5.	86	14	0	0	10	90	80	10	10
6.	17	14	69	39	39	22	15	25	60
7.	0	22	78	95	5	0	25	25	50

(from: Diana Marion Linton, "Value Differences Between Nurses and Low-Income Families," *Nursing Research*, Jan.-Feb. 1972, pp. 46-52)

PREJUDICE

In cases where the patient has been labeled, effective care will not be resumed until the patient's individuality is recognized and reinforced.[12 13]

How does this destructive labeling persist? It can and very often does occur innocently during report. A nurse, who has never seen the patients before will hear opinions instead of facts from the nurse going off duty. In an attempt to be helpful the nurse will include in her report that "Mr. Smith is a bit of a hypochondriac...Ms. Jones was very demanding all shift...and Mr. Brown was a pain in the neck." And so prejudice is spread by the use and repetition of labels. A fresh, unbiased nurse, if she accepts these judgments, has become prejudiced. This is one of the insidious causes of prejudice.[14]

4 Decreased communication: Prejudice can have a very detrimental effect on communications; in many cases, what is actually said may be colored by what the listener expects to hear. This kind of interference not only affects patient-nurse communications, but may be found in nurse-supervisor, nurse-nurse and interdepartmental exchanges as well. A floor nurse may think that the supervisor does not have a realistic understanding of the situation and so discount what she says. Another nurse may judge a co-worker on the basis of that nurse's educational background rather than on performance.

Van Dersal outlines some rules for listening. He says, "You cannot listen effectively if you are overawed or impressed by the speaker's title, name, rank, degree, uniform, wealth or position."[15] The reverse also holds, that you cannot listen effectively if you have a low opinion of someone because of their title, rank, degree, etc.

The topic of communication deserves a great deal of specific attention but a generalization can be made with regard to prejudice. Preconceived ideas distort meaning and may even prevent a person from wanting to communicate.

5 Permanent damage to egos of individuals: Being the target of discrimination can cause personality damage and mental illness. This is a sad and far-reaching effect of prejudice that may not be noticed directly in the hospital but infects society at large. Nurses who are not aware of their own prejudices are adding fuel to the fire.

For example, homosexuals as a group are the target of many prejudices. In an article on homosexuality,[16] an experiment is described which tests the assumption that homosexuality is an illness. The subjects consisted of two groups — a group of homosexuals who did not wish to change their sexual orientation and were not seeking psychiatric help, and a group of heterosexuals. A wide battery of psychological tests were administered and results were evaluated by experts who did not know the sexual orientation of the subjects. Just as many homosexuals as heterosexuals were rated well-adjusted and the experts were unable to distinguish between heterosexuals and homosexuals from the tests. It was found that some of the traits and attitudes regarded as typically "sick" homosexual behavior are really characteristics of rejected minority group members. It seems that traits called "sick" may be caused by rejection — not by homosexuality.

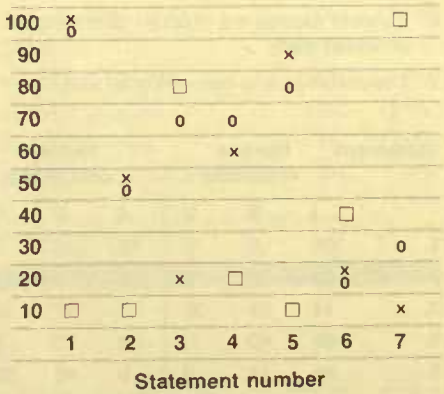
Don Kilhefner, Executive Director of the Gay Community Services Center of Los Angeles, gives a moving description of this plight: *When you find yourself constantly being called abnormal and sick it ruins your self-esteem and erodes your humanity. We have looked into the eyes of society and seen that we are considered repulsive undesirable people. Many of my brothers and sisters have internalized these values and hate themselves. They are ashamed, guilt-ridden and afraid.*[17]

6 Loss of patients' trust: Patients who feel discriminated against by health care personnel will think less of the care they receive and may be less likely to seek help again. There is a greater possibility that this problem will arise when patients differ from health personnel in race, socioeconomic background, values etc. In some cases, the patients' condition may be prejudged and the patient may not feel he or she has been given a proper "hearing."

One young woman described such a case in the following way: In the fall of 1974, when Mrs. Ford's and Mrs. Rockefeller's

Table 3

Graph illustrating correlation between Nurses' attitudes and Mothers' attitudes



PREJUDICE

mastectomies were widely reported in the media, she noticed a painful area in one breast. After a few weeks, when the soreness did not go away, she decided to see a doctor. The treatment she received at the doctor's office was adequate but she was bothered by an attitude she sensed. The doctor seemed to imply there could not possibly be anything wrong, because the patient's complaint was probably triggered by the news stories. It seemed that the examination was done in a somewhat patronizing manner to humor the patient. Whether or not this was the case, the woman felt prejudged and was certainly not reinforced to practice preventive medicine. Such attitudes will cause people to avoid health care workers, in some instances jeopardizing lives.

Approaches for Reducing Prejudice

To reduce prejudice nurses must first learn to recognize it in themselves and then seek changes in the social structure that permit the existence and spread of prejudice.

1 *Recognizing prejudice:* The above examples illustrate that prejudice can find its way into every action, every thought, every word. Because prejudice is such a prevailing influence, guarding against it is no easy matter. Nurses must be aware of its presence, and understand the causes and outcome of prejudiced thinking. Although prejudice is learned, "there is no point in criticizing our parents for passing their prejudices on to us. A more constructive approach is to be aware of them, modify our thinking and feeling if we are able and to understand how prejudice may be operating in our interpersonal relations."[18] By understanding what prejudice is and does, we can work as individuals or in groups to identify hidden prejudices. "Most of them tend to have judgmental overtones. In fact, the moralistic aspects of them are apt to conceal the fact that they are basically prejudices."[19]

2 *Changing the social structure:* In trying to understand why prejudice occurs, it is only useful to a point to recognize it as an individual failing in oneself. It is even less useful to point it out in someone else, since this will not be met with enthusiasm. It is more productive to look at the system.

What is it in the social structure of our work situation that promotes prejudice? It all has to do with status. Most modern health professionals espouse the view that *all* members of the health team are equals, each with different talents and functions. For some time, nurses have been concerned with raising their own status on the health care team to coincide with this view of equality. But what about the status of patients? This is usually glanced over quickly by saying that the patient must also be considered part of the health team. This is a popular attitude, but is it achieved?

Why is it that nurses sometimes do not give optimal individual care?

Why is it that patients' problems can be overlooked or misinterpreted?

Why is it that prejudices about patients spread among nurses?

Why is it that distortion occurs in patient-nurse communications?

Why is it that patients' egos are pushed towards weakness instead of strength?

Why is it that patients lose trust and don't return for needed health care?

One answer to all these questions is that patients are not treated as individuals with equal status, in spite of the fact that it is their bodies, their minds, their lives. They occupy a different and lower position on the health care team. The nurse is accustomed to being in control of the patient, and her role is a very active one. She must make good decisions about patient care based on her education and experience. The patient's role is passive — to receive care cooperatively. Patients are not expected to step out of this role and take an active part in determining their care unless they are invited to do so by the nursing staff, and it is always well-understood that this is a liberty granted to the patient by the nurses.

When the patient's status is not equal, he or she is in a position where decisions are being made for him on the basis of assumptions and he does not have the opportunity to correct misconceptions. In such cases, the patient not only may feel helpless, but prejudice and stereotyping on the part of the nursing staff will tend to increase.

There is a technique for reducing prejudice which may be useful to look at as a possibility for changing the social structure in hospitals. This is called "shared coping," and it involves cooperation to achieve a common goal. "One of the essential characteristics of a shared coping situation is that individuals find themselves in the same situation as equal status partners."[20] The effectiveness of this technique is borne out by experiment[21] and by experience. For example, there are fewer incidents of racial tension in combat zones, where cooperation is critical, than in zones free of crisis.

By approximating a shared coping situation in the hospital it would be possible to raise the status of patients and eliminate situations in which prejudice is fostered. One change that will further this aim is to automatically include patients in conferences about them.[22] Their temperatures, test results and medication orders should be familiar to them, and their feelings and opinions should be consulted in setting realistic goals for nursing care plans. It is a waste of time and effort to make a plan based on goals the patient does not share. Dr. Kübler-Ross writes

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sensitively about the question of whether or not to disclose the diagnosis to a patient, "I personally feel that this question should never come up. The question should not be 'Should we tell...?' but rather 'How do I share this with my patient?'"[23] If patients choose not to enquire about the seriousness of their illness, that is their prerogative, but keeping this decision out of their hands is a self-protective device of doctors, nurses and relatives.

The second suggeston for reducing prejudice is to implement walking rounds at each change of shift. Giving reports in a secluded office or corner permits and promotes labeling. In a private talk, the nurse going off duty is likely to unload many frustrations of the past eight or twelve hours onto the shoulders of the oncoming staff. The man who has been labeled "demanding patient" is not there to tell his side of the story, so naturally the nurse's view is adopted.

There are some difficulties presented by walking rounds, but the rewards could far outweigh them. If the report takes place quietly at the bedside of each patient it will contain a greater percentage of fact than opinion. The report will be short and concise. The oncoming nurse receives the benefit of being able to connect the name and information to a face, and at the end of report she will already have completed a survey round. Lastly, but most important, are the benefits to the patients. Seeing that information is passed on to the new staff will increase patients' confidence in staff. Also, the patient's status will be elevated to that of team member — one who can take part in the exchange of information.

If nurses can convey to patients that they are important and well-regarded individuals with a rightful place on the health care team, then patients can accept this status and take the active, useful role that goes with it. The six effects of prejudice that have been discussed could all be reduced if patients were allowed and encouraged to accept this new role.

Conclusion

Prejudice, whether it involves discrimination against a certain race or simply the stereotyping of a particular patient, has no place in nursing. I believe that the social structure of most hospitals promotes prejudice and discrimination, and encourages a distance between patient and nurse that hinders the provision of optimal care. It is up to us to confront our own prejudices and take the initiative to raise the patient's status to that of partner rather than pawn.

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.egg-Perthes disease is a hip disorder that primarily affects young boys. :s symptoms are often deceptive. Although the prognosis is extremely 'ariable, treatment measures in current orthopedic practice attempt to ensure that the children have a good hip joint to carry them into adult life.

LEGG-PERTHES DISEASE

Celia Nichol

Mrs. White was worried about her five-year-old son, John. For six months he had intermittently complained of pain in his right knee and he had developed a limp. Initial examination of his knee by the family doctor showed nothing, and for a few months Mrs. White dismissed John's complaints as "growing pains." Finally she decided to consult the doctor again and ask for x-rays of John's knee. She was surprised when he ordered x-rays of the hips as well, and even more surprised when the doctor told her John's symptoms were caused by a disease affecting his hip joint, called Legg-Perthes disease.

This type of bone disorder occurs in fewer than one in 800 young boys about the age of John. Mrs. White had never heard of the disease and both she and her son needed a great deal of support and information in order to cope with the resulting changes in their lifestyles.

When treatment was begun, the nurse caring for John was able to offer valuable emotional support to the entire family and over the next few years, until treatment was successfully completed, the Whites came to rely on her as an important member of the team concerned with his care.

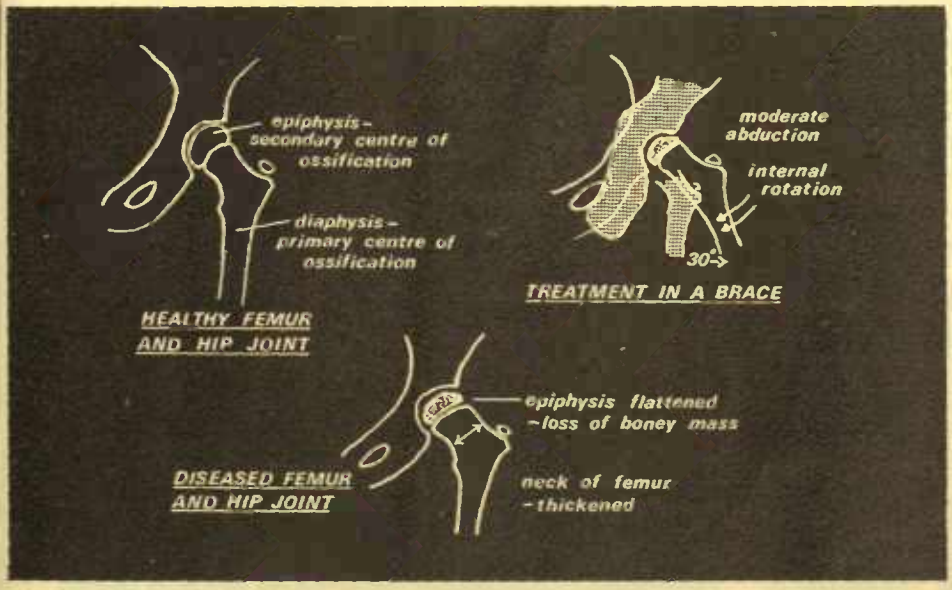


Illustration courtesy of Shirley Mohyudden

The Disease

Definition: Legg-Perthes disease is one of a group of self-limiting disorders of the bone known as osteochondroses in which a boney epiphysis undergoes aseptic avascular necrosis. This is a series of pathological events beginning with an initial loss of blood supply, and progressing to death of the bone and gradual replacement of dead with live bone. Legg-Perthes disease is osteochondrosis of the femoral head.

Known also as coxa plana, osteochondritis deformans juvenilis, and Legg-Calvé-Perthes disease, it was first described in 1910 by Legg, Calvé and Perthes as a self-limited, nontuberculous hip lesion in children. In 15 percent of all cases the lesion is bilateral; the rest occur in one hip only. It occurs most commonly in young boys between the ages of four and eleven years; the incidence is 1:750 for boys compared with 1:3,700 for girls.[1] The exact cause of the disorder is not known but five percent of children who have suffered the relatively benign condition of transient synovitis, or nonbacterial inflammation of the synovium of the hip joint, develop Legg-Perthes disease. It is generally thought that increased hydrostatic pressure within the hip joint, resulting from a traumatic or inflammatory synovitis, occludes the precarious blood supply of the femoral head, inducing the avascular necrosis.

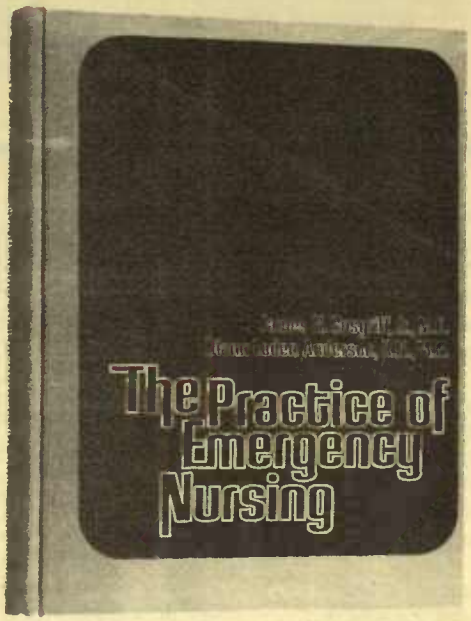
Signs and Symptoms: The signs and symptoms of Legg-Perthes disease are usually insidious and are often lacking in the early stages. The onset of pain occurs acutely in only one quarter of cases.[2] Pain in the knee and/or anteromedial aspect of the thigh and groin of the affected leg, and a protective limp are the complaints most commonly reported by parents.

Pathophysiology: There are two types of Legg-Perthes disease. The whole head type, the most common and the most severe, involves the entire femoral epiphysis; the partial head type affects only the anterior one third to one half of the femoral epiphysis.

The disease spans a period of two to eight years, depending on the age of onset and the

continued on page 34

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Standing (anterior posterior) view, showing Legg-Perthes disease, right hip. Note the changes of avascular necrosis and revascularization; the flattening and appearance of "fragmentation" of the femoral head (due to boney resorption and deposition); the subluxation tendency; and the slightly broadened metaphysis (femoral neck).

type of femoral head involvement, and progresses through four stages. [3]

1 Early necrosis and avascularity — there are few signs and symptoms at this stage.

2 Revascularization with old bone resorption and new bone deposition — during this stage, which lasts one to four years, [4] the new bone has a "biological plasticity" and, depending on the forces that act on it, can be molded into a normal or abnormal shape.

3 Boney healing — eventually the dead bone is resorbed and the new bone gradually ossifies; biological plasticity persists during this stage.

4 Residual deformity — once the process of healing is complete, any residual deformity will not be remodelled, and may result in degenerative joint disease in later life.

Treatment: The treatment of Legg-Perthes disease aims to preserve a useful weight-bearing joint for adult life. The resultant hip joint is affected by several factors: the age of the child (the younger child has a better prognosis); the type of femoral involvement: an early diagnosis; and the type and adequacy of treatment.

Two main principles are followed in treatment: 1) The femoral head must be maintained in the acetabulum in a position of moderate abduction and internal rotation to prevent abnormal molding forces on the biologically plastic head; 2) The stress of body weight must be eliminated from the avascular femoral head as much as possible.

Current treatment varies considerably with the physician. Young children with the partial head type of Legg-Perthes disease can be managed by avoidance of vigorous activities only. Children over the age of four, or with the whole head type, need active treatment.

The child is usually treated initially with Buck's extension or split Russell traction, with abduction gradually being increased until full range of hip motion is obtained.

When full range of motion has been established, the child may be placed in abduction casts or braces, e.g. A-frame, Bobechko Toronto, or trilateral socket braces, until there is radiological evidence of boney reconstruction, and no new areas of bone resorption are seen. This lasts approximately two years, but is variable, and during this time the child must visit his doctor every two or three months for examination and x-rays.

Surgery may be performed before a deformity has developed to prevent or correct subluxation of the femoral head in the child with a poor prognosis. Examples of such operations include a high subtrochanteric (femoral) osteotomy, an innominate osteotomy and a salvage osteotomy. An adductor tenotomy may be done to increase range of motion prior to bracing or surgery.

The outcome of the different treatments for this disorder is extremely variable and depends on the four factors mentioned previously.



Nursing Care

Because the treatment of Legg-Perthes disease is such a lengthy one, its success involves continued coordination of the efforts of the orthopedic team, including the surgeon, the physiotherapist, the nurse and the parents.

To provide the necessary support, the nurse must extend her care and understanding to include the whole family. A previously well child has suddenly developed a serious disorder that will require lengthy treatment and has a variable prognosis. With attention to the needs of the child and his family, the experience can be a time of growing. If it is

poorly handled, the child may develop a crippled personality and family relationships may become seriously damaged. Thus, emotional support of the child and his family represent an important aspect of the total care plan.

In the hospital: When the child is first placed in traction the nurse must keep in mind the fact that he and his family have usually just received the shock of diagnosis. Her care, then, must combine an awareness of emotional needs with knowledge of the basic principles of traction care and an understanding of Legg-Perthes disease.

The young child may understandably react negatively to his enforced traction. Used to being healthy and active, he will find it difficult to *lie* in bed constantly, and it will tax the ingenuity of parents and staff to keep him lying down without constant nagging. Traction can be made more attractive for the child by decorating the area with stuffed animals, the child's art work or get well cards. In addition, support from parents and staff, understanding of his frustration, and planned diversionary activities, such as transporting him in his bed to the children's play area, will help him to cope with his feelings.

The child in traction *must* maintain the correct posture, as determined by the doctor. It is a good idea to affix a sketch of the desired posture over the child's bed so that anyone entering the room can check it.

As with all patients in traction, the traction cord needs to be checked regularly for fraying and correct position in the pulley track. Weights should be hanging freely. Neurovascular status of the leg(s) in traction should be checked every four hours if possible (at least every eight hours), paying attention to warmth, color, capillary filling and response to pin prick of toes.

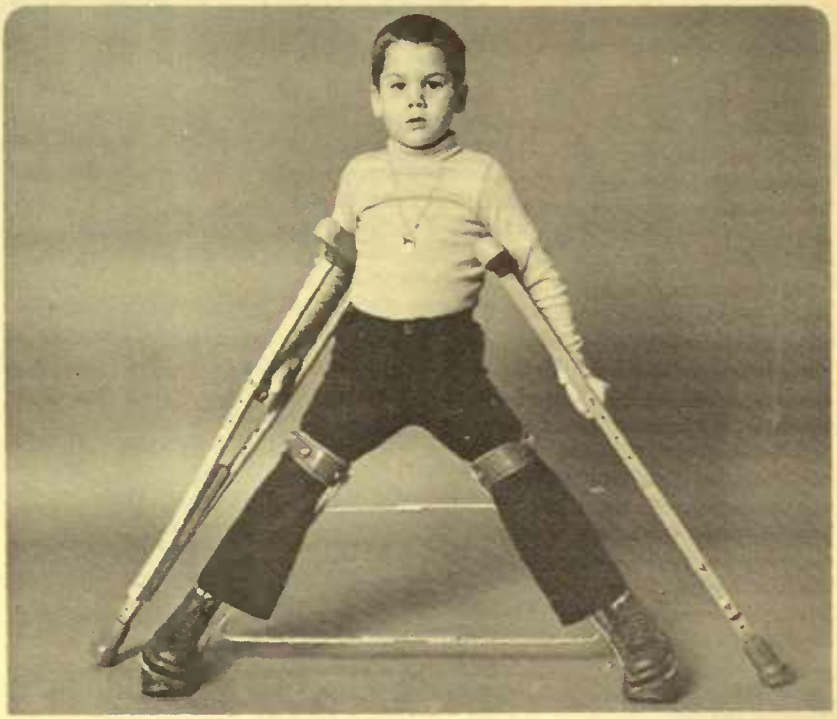
If adhesive straps are used for traction, the surrounding skin should be checked for signs of irritation such as rash, blisters and complaints of itching. If nonadhesive straps are used, they should be removed every four to eight hours for skin care. The bandage should be rewrapped each time from the ankle to the knee and should be loose enough to insert a finger underneath. The skin under these straps should be observed for 20 - 30 minutes for redness that does not disappear; this could be a sign of tissue necrosis. Neurovascular assessment should be done one half hour after bandages are re-applied, as a measure of tightness or looseness.

Good skin care should be given to the rest of the child's body, paying close attention to boney prominences.

While in traction, the child may be measured for his brace. Some doctors initially place the child in abduction casts, so that by the time his braces have been made they present a very attractive alternative to him. With gentle but firm support most children adjust fairly well to their braces.

Before the child leaves the hospital the nurse must ensure that he and his parents have enough knowledge and understanding of home care so that the child can live as normal a life as possible without discomfort.

Most braces used for treatment of Leff-Perthes disease are worn on both legs* and children must use crutches to walk. Most learn to use a swing-through gait, swinging both legs through the crutches at the same time. The nurse should be sure that the parents and child understand the use of crutches as taught by the physiotherapist, or offer definite guidelines if the latter is not available. She should also stress safety measures in the home, such as daily checking the crutches for loose screws and worn crutch tips, and modifying the home environment for crutch usage, e.g. taking up scatter rugs.



Pictured on opposite page is a six-year-old patient in abduction casts; above, another patient in an A-frame brace demonstrates the stance of the swing-through gait.

The nurse should also review with parents, some special care aspects of the child in braces. For example: 1) Daily skin care with alcohol should be given to boney prominences in contact with the brace; the use of alcohol will toughen the skin against irritation, whereas lotions soften it and powders cake. 2) At the same time, skin should be checked for areas of irritation. 3) The plastic molds of the braces should be cleaned daily with soap and water, and the leather cuffs cleansed with leather rubbing compound.

The child should not experience pain while in his braces. The braces will need adjustment as the child grows and parents should watch for indications such as a tight cuff

** The exception is the trilateral socket brace which is worn on the affected leg only. With this type, the child can eventully manage without crutches.*

or brace joints incongruous with the child's joints. Adjustments are made by the doctor or orthotist.

Braces are removed daily. At this time, the child may have an exercise program to do with his parents, assigned by the physiotherapist and/or doctor. Some parents find that evening, before or after the child has gone to bed, is the easiest time for exercising as he is usually more relaxed at this time.

Certain activities may be recommended by the doctor, including such things as tailor sitting and sitting or lying prone with legs in abduction. Swimming is sometimes permitted. Light touch weight-bearing with crutches is often preferred to non-weight-bearing which can increase the tendency towards flexion contracture. These and other specified activities should be reviewed by the nurse to be sure the rationale is understood and to answer any questions.

If surgery has been necessary, posoperative care of the child with Legg-Perthes disease will vary with the surgery performed. Often a cast will be employed, in which case the principles of good cast and skin care should be followed.

Public Health Aspects: Often it is the public health nurse in the community who provides the ongoing home support for the child with Legg-Perthes disease and his family. Thus, to meet the total needs of this family, it is important that good communication exist between hospital or clinic nursing staff and the nurse in the community. The latter should also maintain contact with the child's teacher and school nurse, whose understanding of the disease can be beneficial for the child and his peer group relationships.

The public health nurse should have a good general knowledge of Legg-Perthes disease to be able to answer questions, clarify information and help solve problems that occur at home. She needs knowledge of brace care and of when to call the doctor in case of problems. It is helpful if she understands the principles behind the exercise plan and sitting postures in order to reinforce the doctor's and/or physiotherapist's explanations.

Emotional support from the community nurse can help the parents, the afflicted child and his siblings to cope with the inevitable frustrations imposed by this disease. Listening and empathizing are important to ensure the emotional well-being of the child and his family.

In addition, the public health nurse has an important role to play in the early detection of Legg-Perthes disease. She should encourage medical examination of young boys with complaints of knee pain and limping, and ensure that radiological studies include the hip as well as the knee.

In conclusion, the nurse involved in the treatment of Legg-Perthes disease is in a position to give the child and his family continuing support. Her knowledge and understanding of the disease and its treatment, combined with this continuity of care, are important in ensuring the child's emotional health and minimal disruption to the lives of himself and his family.

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4 Ibid. p. 274

Celia Nichol (B.Sc.N., Ottawa University) has worked in a variety of public health settings. As a student she did volunteer work for community service organizations (including a "well baby clinic" and an "after-four project"), and worked a Fisher River Indian Hospital in Hodgson, Manitoba. When she graduated in 1973 she became Public Health Nurse for Renfrew County and District Heath Unit. Since 1974, she has been on the staff of the new Children's Hospital of Eastern Ontario in Ottawa, as Public Health Nurse in the Orthopedic Outpatient Department. The clinic serves children with a variety of orthopedic problems such as congential hip dislocation, Legg-Perthes disease, muscular dystrophy, scoliosis, etc., as well as providing follow-up care after orthopedic surgery or fracture. Nichol believes nursing care must reach beyond the acute care setting, and says, "I like working with people, particularly in the context of the home environment where the person actually has to cope with his problems. In the clinic, I try to equip the patient and his parents with the knowledge and skills to cope at home, keeping in mind not just the patient's physical needs but his emotional needs as well."



The author would like to thank Dr. W. McIntyre, head of the Orthopedic Department, Children's Hospital of Eastern Ontario, for his many patient explanations and answers to questions.

Four nurse teachers (the authors), from four different schools of nursing, tell how they achieved their goals when charged with the responsibility of developing a clinical evaluation tool for student nurses enrolled in a newly developed Community College Program.

A clinical evaluation tool for student nurses

June Morton, Ann Stinson, Jan Wagstaffe, Marie Yakimoff

Background

The process of transferring nursing education in the province of Ontario from the traditionally homogenous diploma school of nursing to the heterogenous college, is now complete. Nine years of organizational conflict and growth were required to make this transition a reality. Traditional beliefs about learning, teaching, and nursing were challenged, in particular, the notion of "feedback" became an extremely relevant concept in nursing education. Curriculum effectiveness, it was realized, could only be assessed by comparing student performance with predetermined behavioral objectives. To enable teachers and students to evaluate clinical performance, more reliable methods of collecting behavioral data were needed to identify the elements upon which fairly accurate judgments could be based.

At the request of the chairman of the department of nursing of one of these community colleges (Mohawk College, Hamilton, Ontario), the authors undertook to develop a clinical evaluation tool that would assist teachers in obtaining this information about their students. The initial recommendation came from the college faculty Task Group on Student Evaluation for the Department of Nursing. As a preliminary step, the authors identified and accepted a specific short-term goal: *"To have an effective Clinical Evaluation Tool for Semester 1 of the new school year, available prior to the summer vacations"*
and a long-term goal: *"To have similar evaluation tools developed for each of the following five semesters, at least six weeks in advance of the time they would be needed (to allow time for printing)."* The strategies they utilized to achieve these goals follow.

Input from other sources

Prior to establishing the "design criteria" and the "performance goals" for our system, we obtained input from numerous sources, including:

- The school philosophy, because our tool had to reflect its concepts. These included:
— promotion of growth, development, and self-actualization of the student;
— learning involving the whole person;
— dignity and worth of the individual;
— the preparation of a competent beginning nurse practitioner who would be able to assess patient needs, plan, implement, and evaluate her nursing care;
— System's Theory as the conceptual framework for the curriculum.
- Our views and those of our colleagues about the purpose of clinical evaluation. Words like "growth-promoting," "ongoing," "feedback," "systematic," "fair," "the total person," "dignity," and "cooperative process," kept creeping in. We agreed that even though the evaluation we were considering involved student output, the process also allowed for increased growth for the teacher.
- The Task Group on Student Evaluation for the Department of Nursing. The chairman outlined the "raison d'être" of this committee, what it had accomplished, and how it saw our role. In addition, the members discussed with us our responsibility in remaining within the general College framework of evaluation, i.e., students were to receive marks of 1 to 4 for clinical performance. Collaboration with the Task Group saved us a great deal of time, since its members had already done considerable research on evaluation, particularly at Mohawk College.
- The course outline for Semester 1. We familiarized ourselves with the expected behaviors in the new curriculum, and noted the levels at which they were to be performed.
- The evaluation forms that had been used by the four campuses prior to entry into the College system. In addition, we reviewed the evaluation form used by the local university for their student nurses.
- Journals of Nursing, to seek data related to rating scales. Our readings indicated that:
— between 1959 and 1964, four major researchers (Tadlock,[1] Palmer,[2] Rhines,[3] and Tate[4]) developed rating scales and used these in certain select clinical areas quite successfully;
— in 1967 at Wayne State, Slater [5] developed a rating scale that measured individual characteristics and actions rather than skills;
— in her article "A Problem That Won't Go Away," Vivian Wood [6] saw a place for rating scales in clinical evaluation. However, she cautioned that most faculty require more education to use these effectively.

The committee felt that the grading system established by Mohawk College could be supported by rating scales.

- Jurgen Ruesch's four postulates regarding "General System's Theory and the Observation of Behavior"[7]. What impressed us most was his ability to prove mathematically that evaluation was *always subjective.*
- Fivars and Grosnell's *Nursing Evaluation: The Problem and the Process,*[8] and Flanagan's *Clinical Experience Record for Student Nurses — Instructor's Manual.*[9] We were impressed by the research that eventually led to their "Clinical Performance Record" and "The Critical Incident."
- Counsel was sought to discuss the legal aspects of student evaluation and related documentation, in view of the fact that in some provinces:
— Students and/or their guardians have access to all personal records;
— the student has the right to obtain legal counsel to represent him/her at meetings related to termination etc. Obviously evaluation forms must supply accurate, relevant information. This would only be possible if performance goals were clearly stated.
- Faculty members attending graduate school and persons who had attended recent workshops.

Design criteria:

After compiling our data on current evaluation theories and programs, we were able to formulate the design criteria for our tool. These were:

I Evaluation to be effective must be based upon specific behavioral objectives.
II Evaluation should be a co-operative, ongoing process involving student and teacher.
III Evaluation should occur in an atmosphere of mutual respect and should promote growth in teacher and student.
IV Evaluation designed along the lines of the nursing process should be relatively easy for the student to apply.
V Clinical evaluation must be based upon the objectives identified by the curriculum committee in the course outline.
VI Concepts of evaluation need to be presented to the student so that emphasis is on "growth" and "learning."

Organization of Format

Based on criterion IV, the Clinical Performance Record developed by the committee contains ten major areas of behavior to be evaluated. These correspond to the stages involved in the Nursing Process. They are:

— attitude to learning
— observing, data gathering, assessing
— communicating
— identifying patient needs
— developing a plan of care
— implementing a plan of care (physical-psychosocial)
— evaluating and revising the plan of care
— accepting nursing responsibilities
— adapting to new and stressful situations
— integrating and self-appraisal.

Within each of these areas or subsystems, the behavioral objectives specific to that subsystem are identified for the level for which the tool is to be used. In other words, the specific objectives are determined by the objectives in the course outline(See Figures 1.1 and 1.2).

Procedure

The Clinical Performance Record, it was decided, would be filed in the Learning Resource Centre, and students would be allowed to see their own file on request. Initially, the students were to receive their own copy, but cost made this impractical. Instead, each student was provided with a guideline listing all specific clinical behaviors on which he/ she was to be evaluated during the semester (See Figure 2). Whenever a student rotated to a new teacher (every six weeks), the teacher would prepare a new Clinical Performance Record for him/her. The student would receive a new guideline with the appropriate objectives at the beginning of each semester.

The committee recommended that the Clinical Performance Record *not* form part of the student's permanent record, but rather that two Summary Records of "strengths" and "weaknesses," completed by both the student and the teacher be used for that purpose(See Figure 3). The Clinical Performance Record would promote growth and development within the student, without the associated tension that permanent records induce. This recommendation was supported by faculty and administration. The Summary Records (by student and by teacher) would be handed in to the office of the campus head, and Clinical Performance Records would be filed in the Learning Resource Centre for three years.

Our committee agreed with experts who claim beginning students have difficulty evaluating their own behavior and writing self-evaluations. Therefore, we recommended the use of a daily *Clinical Diary* to facilitate their interactions with the teacher about "my day" on the unit, his/her feelings about it, and his/her thoughts. By Semester 3, however, we felt students should be capable of writing a self-evaluation associated with clinical performance.

Feedback

Once our plan was formulated, we asked to speak at a faculty meeting of the department of nursing. We gave everyone a copy of the plan, an instruction sheet, and a questionnnaire and described our progress from the time we had started. We encouraged feedback through questions (and there were many). The rating scale we had set up to correspond with the specific behaviors was unanimously vetoed. About half the faculty were concerned about the time factor involved in keeping the performance record up-to-date. (The committee estimated that this would take a teacher about three hours per week if she had ten students).

Faculty were asked to review the tool carefully and to complete the questionnaire within a week. Approximately 75 percent responded, some verbally, but most through the questionnaire. We received many good ideas. In general, two of the four campuses were quite positive about using the Clinical Performance Record and the Summary Records; the other two were not. We adopted any ideas that could be adapted to our tool, and sent it to press. Semester 1 evaluation forms were completed and so was the school year.

In September, our committee visited the four campuses and reintroduced the clinical evaluation tool and its method of utilization. There were still some teachers who felt the time involved outweighed the value of the Clinical Performance Record; however, they were willing to cooperate. Teachers were encouraged to discuss behaviors with students as soon as they occurred and to use the problem-solving approach.

Faculty and our committee decided together that the form would be introduced in a positive way to the students by their own clinical teacher at the beginning of Semester 1.

Students and teachers were told that they would be asked to evaluate the clinical evaluation tool at the end of the first, third, and sixth semesters, and that appropriate revisions would be made. Feedback received from the first evaluation, we felt, was significant in that 85 percent of the students and 82 percent of the faculty members responded to our questionnaire.

Since the main emphasis in education is on "helping the learner to learn," we were most gratified by the student responses. Of the students who responded, most felt that the form was worthwhile. Teacher remarks, on the other hand, emphasized the amount of time spent in completing this record. The committee's original estimate of three hours weekly proved correct.

Suggestions made by faculty to improve the Clinical Performance Record included the following:

- Increase the space for comments.
- Combine the Clinical Performance Records for Semesters 1 and 2, as it was impossible for all students to complete all clinical objectives in the first semester.
- Make objectives relate to specific skills.
- Generalize the objectives a little more.
- Have a workshop to review the use of the evaluation forms and to find a faster way of completing the forms.
- Change the wording of some objectives in order to make them more meaningful.

As a result of this feedback, several events occurred:

— the committee discussed and assessed the suggestions and comments of faculty and students;
— survey results were presented to the faculty at a general meeting;
— action was taken on all student and faculty suggestions, except the request for more specific objectives, as this would have meant increasing the length of the Performance Record and the time involved in completing it. However, we did clarify vague objectives.

Performance Records for Semesters 3,4, and 5 were combined for the same reasons as were 1 and 2. Since students rotate through Obstetrics, Pediatrics, Psychiatry, Medicine, and Surgery during these semesters, a more generalized evaluation form was required. The ten major areas or subsystems to be evaluated remained the same as in Semesters 1 and 2. The specific behaviors were those included in the course outline for Semesters 3, 4, and 5. When the third semester rotation was completed, we had the Clinical Performance Record evaluated by students and teachers. For ease in tabulating results, Likert-type scales were used (See Figure 4).

Like our other Performance Records, the form for Semester 6 is based on course objectives. Since students probably will be evaluated by head nurses and team leaders during the latter half of this rotation, as well as by their teachers, consideration was given to the limited amount of time these persons have to participate in the evaluation process. Therefore, the Semester 6 form, although still containing all the major areas of behavior that the student had been evaluated on for two years, will now have the specific behaviors followed by Likert-type scales (See Figure 5).

The head nurse will be encouraged to discuss her opinions with the students, and the student will be asked to complete a Summary Record (as done in past semesters) that will be attached to the head nurse's evaluation. These will be forwarded to the permanent file. In addition, each head nurse will receive a letter from this committee describing the purpose of the evaluation form and her responsibility associated with it. Her opinions regarding the Clinical Performance Record will be sought in writing.

Conclusion

Both our short-term and long-term goals have now been achieved. More than 400 students have begun their clinical experience in Semester V at Mohawk College. Because of the faculty's commitment to the clinical evaluation tool, we feel these students possess (and will continue to demonstrate) increased:

- self-confidence on the clinical unit;

Figure 1.1

Clinical Performance Record (Semesters I, II)

Mohawk College of Applied Arts and Technology
Health Sciences Division, Department of Nursing

Areas of Performance	Date	Item	Effective Behavior	Date	Item	Behavior Needing Improvement	Date	Item	Corrected Behavior
1. Attitude toward learning									
a. Completes the pre-clinical assignment given by her teacher.									
b. Seeks guidance appropriately from a reliable source.									
c. Accepts and learns from guidance received.									
d. Makes significant contribution to pre- and post-conference.									
e. Is developing skills in group dynamics.									
f. Independently seeks new learning experiences.									
2. Observing, data gathering, assessing									
a. Checks nursing care plans and charts regularly.									
b. Notes patients' usual pre-hospital routines.									

Figure 1.2

Clinical Performance Record (Semesters III, IV & V)

Areas of Performance	Date	Item	Effective Behavior	Date	Item	Behavior Needing Improvement	Date	Item	Corrected Behavior
1. Attitude toward learning									
a. Completes the pre-clinical assignment in depth and detail.									
b. Independently seeks new learning experiences.									
c. Recognizes the needs for guidance and seeks it appropriately.									
d. Accepts and learns from guidance received.									
e. Helps others apply theory.									
f. Shows leadership ability in group discussion.									
g. Makes significant contributions to pre- and post-conferences.									
2. Observing, data gathering, assessing									
a. Checks nursing care plans and charts regularly.									
b. Checks that medications, treatments and nursing care are consistent with patient safety.									

Figure 2

Clinical Experience Record (Semesters III, IV, V)

1. Attitude toward learning

a. Completes pre-clinical assignment in depth and detail.
b. Independently seeks new learning experiences.
c. Recognizes the need for guidance and seeks it appropriately.
d. Accepts and learns from guidance received.
e. Helps others apply theory.
f. Shows leadership ability in group discussion.
g. Makes significant contributions to pre- and post-conferences.

2. Observing, data gathering, assessing

a. Checks nursing care plans and charts regularly.
b. Checks that medications, treatments and nursing care are consistent with patient safety.
c. Observes and interprets physical manifestations of her patient.
d. Observes and interprets psychological manifestations of her patient.
e. Uses the assessment tools to gather information.

3. Communicating

a. Utilizes interviewing techniques with patients and families.
b. Communicates effectively with teachers, peers, patients, and health workers.
c. Interacts constructively with group members.
d. Provides health teaching and explanation of procedures at the patient's level of understanding.
e. Communicates effectively in writing (anecdotes, process recordings, nursing care plans).
f. Records and reports physical and psychological manifestations in her patients.
g. Records and reports pertinent data regarding treatment and/or nursing care given.

4. Identifying patient's needs

a. When questioned, demonstrates knowledge of scientific principles and nursing theory.
b. Identifies the physical, psychosocial and spiritual needs which the patient cannot meet.
c. Identifies appropriate nursing care for patient needs.

5. Developing a plan of care

a. Utilizes knowledge of nursing theory.
b. Considers individuality and maturational level of patient.
c. Establishes patient and assignment priorities in previously experienced situations.
d. Establishes long- and short-term goals for nursing action in previously experienced situations. Is able to state the rationale of these.
e. Develops a plan of care for her assigned patient.
f. Plans for appropriate health teaching.

6. Implementing a plan of care

A. Physical

a. Applies theoretical knowledge.
b. Maintains a high level of proficiency in previously achieved skills.
c. Applies principles of asepsis.
d. Demonstrates manual dexterity.
e. Ensures the comfort and safety of the patient when giving care.
f. Provides a safe, orderly and comfortable environment.
g. Demonstrates organizational ability.
h. Completes assignment in a reasonable length of time.
i. Teaches patients and visitors principles of asepsis.
j. Utilizes health teaching to prepare individuals for return to family and community.

B. Emotional

a. Nurse-patient and nurse-family interactions are purposeful and therapeutic.
b. Demonstrates the ability to reflect feeling tones inherent in patient communication.
c. Responds to patient comments in non-judgmental manner.
d. Offers appropriate support in periods of apparent stress.
e. Establishes, continues and concludes a supportive relationship with a patient who has an emotional problem.

7. Evaluating and revising the nursing care plan

a. Identifies changes in patient needs and nursing problems as they occur and modifies or revises the plan.
b. Determines the effectiveness of nursing care in terms of the nursing care plan and the total treatment plan.
c. Validates her findings with her patient, her clinical instructor, team leader and/or physician.
d. Supplements knowledge and develops skills as needed.
e. Evaluates the teaching process and revises it if necessary.

8. Accepting of nursing responsibilities

a. Assumes responsibility for own actions.
b. Maintains ethical standards and proficiency according to nursing principles.
c. Aware of own limitations and refers situation to appropriate personnel.
d. Follows established policy or procedure.
e. Voluntarily assumes extra duties within limits of responsibility.
f. Conserves hospital supplies.
g. Demonstrates knowledge of proper care and use of equipment.
h. Uniforms are worn as required.
i. Is punctual.
j. Understands and carries out legal responsibilities associated with nursing.
k. Cooperates with other health team members in giving patient care.

9. Adapting to new and stressful situations

a. Requires minimum guidance in adjusting to new situations.
b. Performs new skills satisfactorily and efficiently.
c. Performs skills learned in previous semesters, calmly and efficiently, under stress.
d. Recognizes manifestations of anxiety in her own behavior and seeks appropriate ways to reduce them.
e. Reacts appropriately to situations which require immediate attention.

10. Integrity and self-appraisal

a. Recognizes own assets, potentials, limitations as well as utilization of coping mechanisms.
b. Realistically and honestly evaluates her own performance and seeks appropriate assistance.
c. Evaluates her interpersonal relationships.
d. Evaluates her ability to problem-solve.
e. Identifies and reports her own errors even if unnoticed by others (e.g. isolation, surgical asepsis, drugs etc.) and attempts to correct them.
f. Identifies and reports incidents and accidents that endanger the patient.
g. Demonstrates respect for dignity and worth of patients and co-workers.
h. Is discriminate with confidential information.
i. Demonstrates an awareness of her own health needs.

Figure 3

Summary Record of Clinical Performance for Semester

Name

Clinical area

For period beginning To

Hours offered Hours absent

Grade

Areas of strength and weakness:

Student/Teacher comment:

Signature of teacher: Signature of student:

Date: Date:

Figure 5

Clinical Performance Record (Semester VI)

Areas of Performance	Check Appropriate Column				
1. Attitude toward learning	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
a. Completes pre-clinical assignment in depth and detail.					
b. Independently seeks new learning experiences.					
c. Recognizes the need for guidance and seeks it appropriately.					
d. Accepts and learns from guidance received.					
e. Shows leadership ability in group discussion.					
f. Helps others apply theory.					
g. Makes significant contribution to team meetings.					

Figure 4

1. a. The concepts underlying the Clinical Evaluation of student nurses at Mohawk College reflect the philosophy of the school.

b. The main focus of the Clinical Performance Record and of the Summary Sheet appears to be on
— student learning
— student growth

Question #	Agree	Undecided	Disagree
1 (a)			
1 (b)			
1 (c)			

c. The specific reason for creating the Clinical Performance Record was to assist teachers and students identify
— behaviors that would indicate the learner had achieved the clinical objectives outlined for Semester III.
patterns of strengths and/or weaknesses demonstrated by the student during Semester III.

- observational skills on the clinical unit;
- motivation for learning
- growth in the development of nursing skills, including problem-solving;
- willingness to cooperate with others;
- feelings of self-respect and respect for others;
- acceptance of evaluation in general and clinical evaluation in particular.

When this article was written, all four teachers were in the Nursing Department of Mohawk College, Hamilton, Ont.: June Morton, Brantford Campus; Ann Stinson, Civic Campus; Jan Wagstaffe, Chedoke Campus; and Marie Yakimoff, St. Joseph's Campus.

The authors wish to thank Dorothy Lambeth, Chairperson of the Nursing Division, Mohawk College, for the freedom to be a little creative, her trust in their capabilities, and her support.

* *Additional information is available upon request from the authors.*

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STORY BOARDING — A Teaching Tool

Whether you are a staff nurse in need of some specific teaching materials, an in-service director needing to visualize some new technique, a public health nurse or nursing educator with a "message" to deliver — visual materials can be a useful means of organizing your thoughts and of presenting your information. Storyboarding, as the authors describe it, is a technique that offers many possibilities and can be used by virtually anyone.

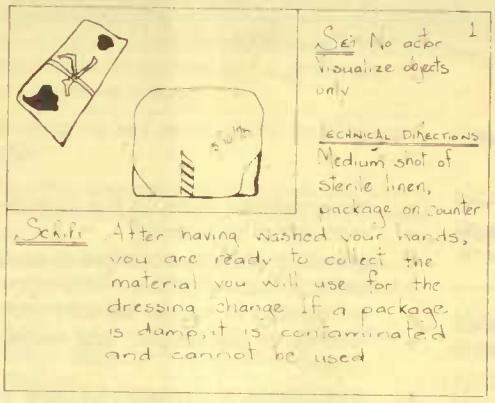
Gloria Dubin, Alison Dunsmore, Darlene Pedersen, Julia Quiring, Robert F. Rubeck

The social sciences suggest that generally communication tends to be most successful when more than one sense is involved. In the example presented here — "storyboarding" — both sight and hearing are used to reinforce the basic message. Borrowed from the "story hour" of children, where pictures were often shown to illustrate stories being read, storyboarding is a technique that can be very useful in the early planning and development stages of any nursing education presentation.

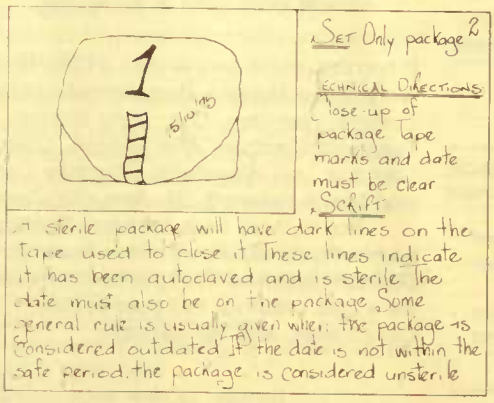
The essence of a storyboard is that it consists of a sequence of cards, each one containing a visual message, a verbal message, and any other details that may be necessary in the final production. Thus, the "story" is planned, suitable pictures, graphics or illustrations are chosen, and each one is mounted on a card with appropriate verbal commentary (see figures 1 to 8). The "boarding" part of storyboarding comes from the board or wall on which the cards are displayed in the proper sequence (see illus.). Using the storyboard, the nurse can test the visual and aural impact of different arrangements of the cards in combination with the dialogue. He or she can then decide on the sequence that offers the audience the greatest impact.

One of the advantages of this technique is that it is a relatively simple method of organizing ideas, yet it can serve as the preliminary step in producing anything from a straightforward lecture that makes use of illustrations, to a very complicated audiovisual presentation. Television and film producers and directors use storyboarding extensively to plan and visualize each step in their production. On a less sophisticated level, the nurse-educator can also use this technique in a number of ways.

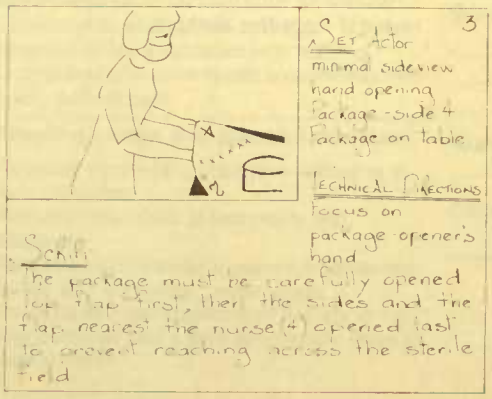
The *technique* of developing a storyboard is always, essentially, the same. However, the length of the storyboard, the details on each card, the format and the "professional" look will vary greatly depending on the use it will be put to. An educator may want to use a

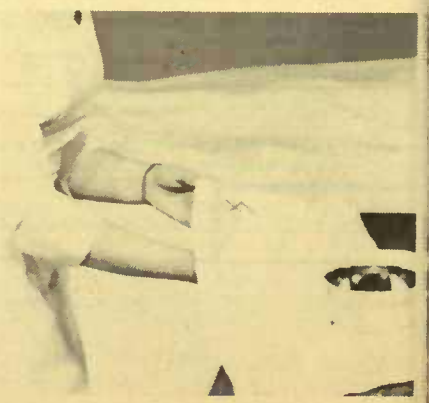












toryboard to visualize a cture-demonstration. In this case, the aterial on each card may be very roughly resented. Yet the educator, and others eaching the same subject, can use the toryboard again and again to plan their essons. The storyboard for a slide show will robably be a little more detailed, and one for a lm or audiovisual presentation will be still nore complicated, particularly if it has to rovide all the material necessary for ameramen and audiovisual experts who may now nothing about the subject, to shoot the ilm.

The storyboard format described in this rticle is not as complicated as that used for TV r film productions and requires little rofessional expertise. Its advantage is that it can be adapted for many different uses without necessarily requiring any complicated audiovisual hardware or talent.

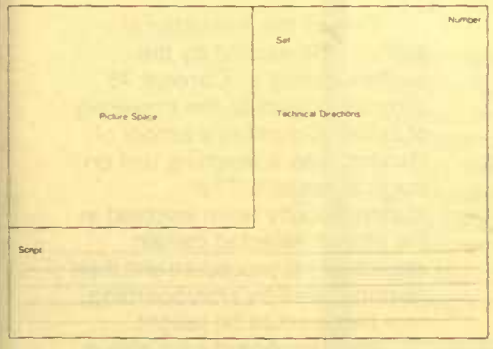
Developing the storyboard

To develop a storyboard, usually a number of cards (3" x 5", 4" x 6", etc.) are essential. Commercial cards can be purchased, but plain ones will serve as well. While "flip charts" or paper can serve the same purpose, these are not likely to be as easy to use, as readily shifted around, or to last as long as the card-type of background.

Each card should have a space designated for picture, script, and, if needed, for technical and set directions. The latter, of course, are much more complicated for audiovisual presentations. Generally, you should use professional graphs, photographs or audiovisual help whenever you can. Such help will be especially useful if you are preparing a slide presentation or a film package.

The format we suggest is this:

(DIAGRAM OF POSSIBLE STORYBOARD CARD)



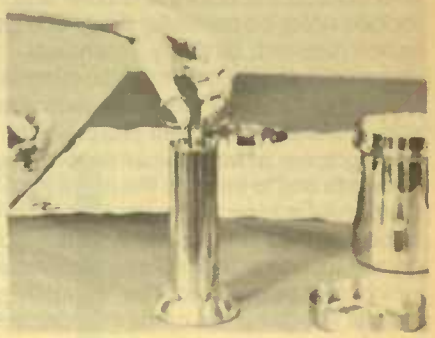
In the "picture" space, you need to indicate as nearly as possible the exact detail you want to stress, or reproduce with illustrations, slides, pictures, or videotape scene in your lecture. Since few of us are artists, crudely-drawn stick figures are usually quite sufficient to depict the scene of the picture. Sometimes combinations of magazine pictures might be cut and pasted together to give a more realistic idea of the scene. The "script" should be written exactly as you want it to be delivered, whether in your lecture or in the final production, even using the same tense and person.

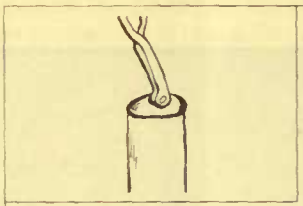


4
Set Actor (hand only) show correct finger-thumb position when removing forceps

Technical Directions
Med + tight on cylinder

Script grasp the forceps by their handles using the thumb and middle finger of your hand the handles of the forceps are contaminated while the part of the forceps below the level of the solution is considered sterile if you touch any portion of the inside of the container not covered with solution, you will contaminate the forceps

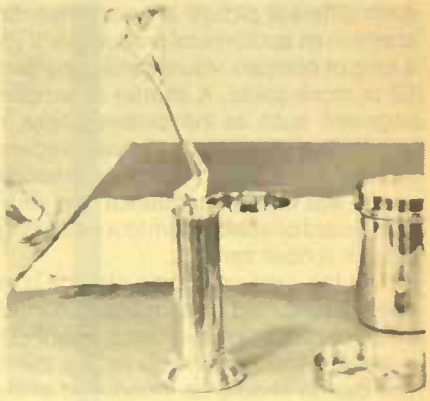




5
Set Actor (hand only) removing forceps

Technical Directions
Medium tight on cylinder container

Script remove the forceps from the container, withdrawing them vertically keeping the tips down & not touch the forceps to the inside of the container above the solution





6
Set Hand only - hold cotton ball in forceps above container

Technical Directions
Med close-up on sterile object in forceps

Script
Lift sterile supplies cotton ball from stock container and transfer it to small basin & do not allow forceps to touch any surface except sterile object





7
Set Remove cover and place inverted on counter

Technical Directions
Med tight on hands and bottle tops to med shot of entire counter

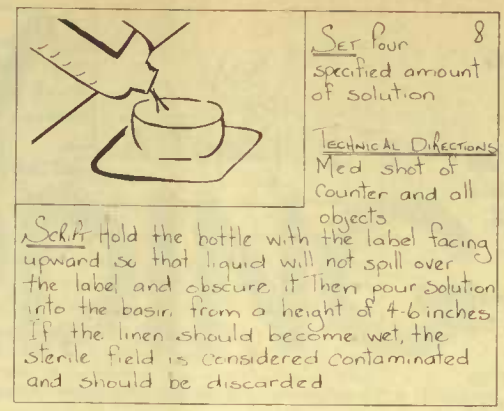
Script
Open the solution container, maintaining sterile technique. Note the position of the lid



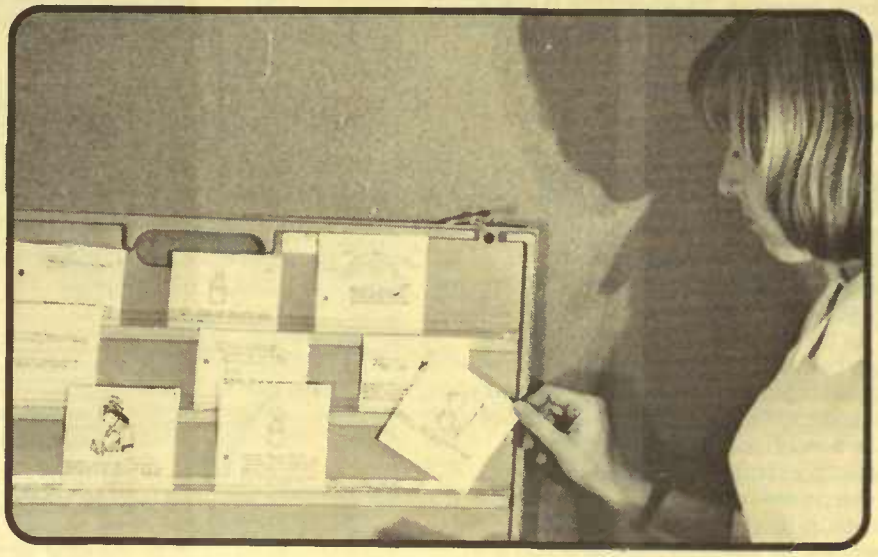
In more complicated audiovisual (AV) presentations the "set" section should give directions to the actors and crew and might include notes on particular props and types of action required. Similarly, "technical directions" should give specific information to the technician — whether the technician is you, a friend, or a skilled professional photographer or audiovisual expert. You need to decide and to indicate the angle from which the picture is to be taken, the amount of scene to be included in the picture, and important details such as written notations, or small parts which *must* be included. The "number" section assists in putting the cards in order quickly.

A separate card should be prepared for each different picture in your presentation or scene in an audiovisual production. If you have a long or complex visual series you may have 50 or more cards. A shorter or simpler segment, such as that pictured here, may require five or six cards. As you prepare them, number them. When you have prepared your cards, slip each in sequence into your storyboard or attach them to a wall using weak tape or rubber cement.

In the card-producing stage it is easy to make single card or sequence changes. For instance, your last two cards might contain material which, when you review the series, you decide should be introduced at the beginning. It is easy to change the sequence at that point — just erase the old number and move the cards over. Or, you might decide some pictures did not have sufficient detail to illustrate a particular point. All you have to do is add in the correct detail on a new card or cards. If filming or taping is being carried out to reach larger audiences or to preserve a communication-education package, each corresponding change requires considerably more effort, and professional audiovisual help may be required.







Conclusion

The process of storyboarding parallels, in many ways, the planning and assessment stages of the nursing process. Using the storyboard approach you can plan illustrations or pictures that complement your text and include sufficent detail to reinforce each major point. The storyboard technique is simple, direct, and effective. The minutes it takes to make storyboard cards are a small investment with great yield in the outcome of the finished production. Whether you need to visualize a lecture, a nursing procedure, or develop a detailed slide-tape series or film of a complex process, the use of this technique will enhance the development of a high-quality product.

The authors were members of a faculty-student team at the University of British Columbia that was involved in a summer project to develop instructional modules for different aspects of teaching.
Gloria Dubin (B.S., University of Maryland) is a graduate student at the UBC school of nursing.
Alison Dunsmore (B.Sc.N., University of British Columbia) is responsible for coordinating instructional materials for second year at the UBC school of nursing.
Darlene Pedersen (B.S., University of Connecticut) is a graduate student at the UBC school of nursing.
Julia Quiring (R.N., Emanuel Hospital, Portland, Oregon; Ph. D., University of Washington) is Associate Professor at the UBC school of nursing.
Robert Rubeck (Ph. D., Ohio State University) is a professor with the Faculty of Education at UBC, and provides instructional design consultation to the school of nursing.

One of the instructional modules developed by the authors during a "Careers 75" summer project at the University of British Columbia's school of nursing, was a teaching unit on surgical asepsis. The student/faculty team involved in the project selected certain aspects of the procedure and then demonstrated by *storyboarding*, how these could be taught.

The storyboard card above depicts the planning aspect. Rough "sketches" are used on each card to indicate the finished protograph, (on the right) or series of "shots". Note that the camera in these cases normally is at the angle of the person doing the procedure. This differs from the usual type of picture taken standing in front of a given subject or object.



It has been the policy of *The Canadian Nurse* to give preference to writers who express themselves in prose rather than poetry but, when this particular poem was submitted to us, the editors agreed that the time had come to make an exception to our own rules. In the letter that accompanied her submission the author wrote:

"For some time I have been concerned about and resentful of the pitying and superior attitude of nurses and other staff because I work in an extended care setting. Some of them are really quite critical; they accuse me of wasting my talents and skills when I could be "putting them to good use" in an acute care area.

In this poem I have tried to show that there is much more to extended care than wet beds and feeds. I realize that you would prefer a scientific article but there are so many articles on this subject that I would find it very hard to sit down and write anything new, whereas the poem just wrote itself — bubbling up with my mounting indignation."

Extended Care

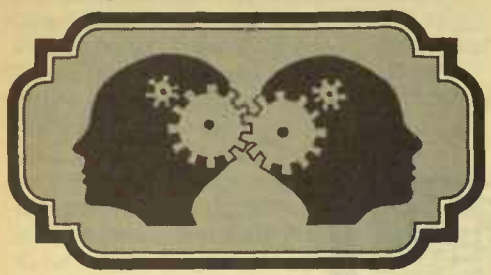
I reach out — my feet, my hands, my head,
To fill the role of those whose strength has fled.
My voice through voids of silence flies — to ring a bell
Within the minds of them so far away, and yet still here
Perchance my smile can generate sufficient warmth and cheer,
To light the spark of hope, encouragement and will
To DO again — when all seems finished, worn, and ill.

I reach out — far, far, beyond this place,
Into the boundless realms of mental space,
Where dwell the fantasies and spirits of confusion.
Dark demons of despair lurk there, along with fright, and fight, and flight,
I meet them, greet them, beat them, with my little light,
My Master's Gift — the torch that I must bear
Unto eternity — His Love and Tender Care.

Pat Nendick,
Shaughnessy Hospital, Vancouver, B.C.



connection



Home Ec, Anyone?

Doreen Scott

Rehabilitation of the psychiatric patient is a continuing process. It begins at the door of the institution when he is admitted and follows him into the community when he is discharged. Along the way, a variety of professional helpers — nurses, psychologists, occupational therapists, social workers, and physicians — try to provide the assistance he needs. For the past two years, patients at Alberta Hospital in Ponoka have benefited from the specialized education and experience of a category of professional not often involved in direct patient care — the home economist. At this hospital, two home economists are part of our rehabilitation team, helping to pave the way for the work of community nurses who will visit patients in their homes after their release and generally help the patient adjust to reintegration in the community.

The role of these home economists is to provide the patient, while he is still in hospital, with the practical living skills he needs to make his return to the community less traumatic. Their job is to develop or restore in the patient the ability to function on a day-to-day level and to cope with problems that arise in ordinary living. The work has been slow and, at times, arduous for persons who have been in a psychiatric facility for a number of years tend to lose these skills because so much is done for them. We are finding, however, that this aspect of our rehabilitation education program does pay dividends by making community immersion less difficult and helping patients maintain the level of well-being they had achieved before discharge.

About two years ago, when we hired two well-qualified home economists, we had only a foggy idea what their role would be and so, I am sure, did they! The first step was to give them a brief orientation to the hospital and to explain that, within the guidelines of the hospital philosophy and objectives, they were free to use their expertise within the seven rehabilitation units and among the 200 residents. On our organizational chart they were made responsible to the Department of Nursing.

Home economics is a study of laws, conditions, principles and ideals that are concerned with man's immediate physical environment and his nature as a social being. It deals especially with the relation between the two, with the purpose of improving the quality of people's daily lives. As home economists, therefore, the two new members of the rehabilitation team sought to provide planned and purposeful activities that would help patients improve or relearn skills for readjustment into the community. In order to do this, they have painstakingly built up a good supply of resource materials, posters, visual aids, sewing machines, and cooking equipment.

Grace Nishi, the first member of the team, began her program on a twenty-two bed integrated unit designed especially for independent living skills. The nursing coordinator, head nurse, physician, social worker, and psychologist, all meet two or three times weekly with the residents to talk about problems and concerns, and Grace was included in these sessions. One of her most successful experiments has resulted from sharing her skills in menu-planning and budgeting. Under her direction, small groups of residents and staff sallied forth into our local town of Ponoka to compare prices of basic foods such as coffee, sugar, bread, cereals, etc. in all the stores. Armed with comparative lists, the unit then approached Administration and asked if they could be truly independent and, not only cook for themselves, but also buy the food! After considerable discussion, a procedural agreement was reached, and they began with a budget of $1.87 per day! The program has been a great success in helping residents learn to cook nutritious meals that are within their incomes upon discharge. Even with today's prices they have managed to keep to the original budget.

Grace and Gwen Johnson, the second home economist on the team, run a collaborative effort; their office is together, they share ideas, and plan programs with one another. Gwen's work schedule is similar, but different because she is responsible for six units. Trying to spread herself amongst the units was like putting butter on every sixth slice of toast. The sixth slice got lots, the other five none at all. Now she concentrates on two wards, and acts as a consultant to the others. The programs she has enriched are now run by nursing staff who work very closely with Gwen. Her positive reinforcement of good personal hygiene has helped their work, too.

Her programs emphasize a variety of aspects of daily living: the first was teeth. On a ward of forty men suffering brain-damage produced by trauma or alcoholism, and a large group of long-stay residents with psychoses of all the need for good personal hygiene is acute. Two small pouches, one with toothbrush and toothpaste, and another for brush and comb, were made available for each man to keep in his bedside locker. The men attended her program weekly, and she reinforced teachings by use of films, posters, and praise. Now, they each have their own kit and brush their teeth daily.

Gwen's weekly cooking programs are well attended. Four to six residents, together with their nursing staff and Gwen, use a special kitchen to completely prepare their dinner. At these sessions, she stresses good personal hygiene, washing hands after using the washroom and before meal preparation. Table manners are also improved since the nursing staff and Gwen emphasize family-style dinners, sharing with one another and learning again to make social conversations. One young man who is dominant and yet explosive in conversation thus discouraging others from speaking up was effectively controlled by the use of tokens. Each person was given five plastic tokens, or for each conversation at the meal. When the five were used up, they were to be silent. This method worked with this man, and helped bring others into the conversation.

Occasionally, persons coming to the group sessions are not well enough to attend. When this happens, the person is asked to return to the unit. More often, the person is able to modify his behavior for the group session and act accordingly. He may be upset on returning to the ward, but in the program his behavior is appropriate for the occasion.

We have asked Gwen and Grace not to wear uniforms and feel that this has helped them to establish a rapport with group members. Somehow, a sparkling crisp white uniform together with cap and pin , although certainly nice when one is sick in bed, sets up an invisible barrier that says the patient is on a different level than the professional.

Gwen and Grace, when not actively engaged in a program, are busy planning the next day or week, ordering films, and trying to attend treatment conferences on the ward. Their written observations of progress help the team to see the hospital residents in a slightly different way. They would like to do more, follow their group members into the community upon discharge but, so far, budgetary constraints have prevented this. They are now planning a workshop on money management for staff as well as patients; they have given classes on consumer information and demonstrations in metrication. They have even been consulted by a resourceful head nurse as to what type of furniture looks best in different-colored rooms, the best fabrics, the maintenance involved, and the best color to repaint the walls on the units.

It is important that they are in a staff relationship to the units, so that in a psychiatric facility like ours, their professional opinions are seen as positive, consultative, and not authoritative which might prove restrictive.

Gwen and Grace meet regularly with the nursing coordinators to discuss their concerns and problems. These meetings have developed a strong collegial relationship that has assisted in evaluating as well as validating their programs in an objective manner. Progress has not been startling but we feel that their input has been valuable, and they are truly membes of the team!

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Names and Faces



Colonel Joan Fitzgerald has retired as director of nursing services, National Defence Headquarters. The first woman in the Canadian Forces to attain that rank in peacetime, Fitzgerald joined the Royal Canadian Army Medical Corps in June 1942, as a lieutenant and served in Canada and Northwest Europe as a nursing sister until November, 1945.

Following studies at the University of Ottawa, she joined the Royal Canadian Air Force in 1948 at Rockcliffe and later spent five months as a flight nurse with the U.S. Air Force during the Korean airlift operations.

On returning to Canada in 1951, she held a variety of senior medical positions in Ontario and Quebec. In 1966, she was transferred to the surgeon-general's office, Canadian Forces Headquarters.

In 1968, she was promoted to wing commander and appointed matron-in-chief of the Canadian Forces. She was promoted to colonel in 1972.

Fitzgerald was the first servicewoman to attend the National Defence College, Kingston, Ontario.



Lieutenant-Colonel J.E. (Jess) Lawson of Campbellton, New Brunswick, has been promoted to the rank of colonel and appointed director of nursing services, National Defence Headquarters, to succeed Colonel Joan Fitzgerald on her retirement.

Lawson joined the Royal Canadian Air Force in 1951 and served as a nursing sister at various air bases in Canada and Germany. She was promoted to major in 1965 and appointed director of nursing, National Defence Medical Centre, Ottawa, in 1969. In 1972 she was appointed career manager, nurses, at National Defence Headquarters, and promoted to the rank of Lieutenant-Colonel in 1973.

Elizabeth Bietsch, Director of Nursing of the Medicine Hat General Hospital for the past twenty-two years has retired. She had been the Director of the Medicine Hat General Hospital School of Nursing for eleven years before it closed its doors in 1971.

An active participant in the affairs of professional nursing groups, Miss Bietsch was a member of the Board of Directors Canadian Nurses' Association from 1955-57 and President of the Alberta Association of Registered Nurses 1955-57. She was recognized by the Alberta Association of Registered Nurses in May, 1975, with an honorary membership. She became a member of the College of Health Service Executives in 1973.

Bietsch, who is living in Medicine Hat, is a board member of the Lutheran Foundation of Medicine Hat, which is planning a senior citizens apartment building for the community.

Ruby Sirons (R.N., Calgary General Hospital school of nursing; B.N., McGill University) has been appointed director of public health nursing of the Wellington-Dufferin-Guelph Health Unit. Formerly nurse-in-charge of the North Waterloo, Ontario, branch of the Victorian Order of Nurses, Sirons has for the past three years been active in establishing a family planning service in Guelph, Ontario, and in making it available throughout Wellington and Dufferin Counties.

Gail Donner (R.N., Winnipeg General Hospital; B.Sc.N., University of Pennsylvania; M.A., New York University) has been appointed Chairperson of the Nursing Department, Ryerson Polytechnical Institute, Toronto. Donner had been instructor for the post-diploma psychiatric nursing course at Ryerson.

Monique Chagnon (R.N., HôtelDieu school of nursing, Montreal; B.N., Institut Marguerite d'Youville; M.A., University of Montreal) was some months ago appointed coordinator of professional inspection with the Order of Nurses of Quebec. Prior to her association with the ONQ in 1974, Chagnon worked at the Montreal Children's Hospital, the Children's Medical Center in Boston, and at



Sainte-Justine's Hospital in Montreal. As associate director at St. Justine's she participated actively in the development of a classification of pediatric patients. She has also made a preliminary study for the ONQ aimed at developing a method of evaluating the quality of nursing care in Quebec.

Anne Wallace (R.N., St. Paul's Hospital school of nursing, Vancouver) has been appointed assistant nurse coordinator of the British Columbia and Yukon Division of the Canadian Cancer Society. Her work involves her in an industrial education program and a mastectomy rehabilitation program that is geared to the health professions.

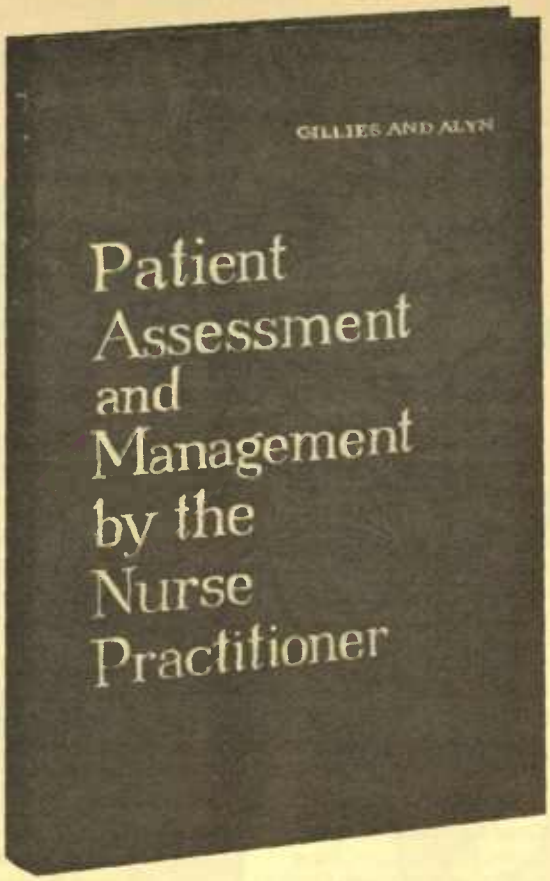


Wallace has included in her experience general duty nursing at St. Paul's Hospital; office nursing with physicians of Vancouver; and occupational health nursing with Woodward Stores of Vancouver. She is currently first vice-president of the Associated Alumnae of the Sacred Heart of Canada and the United States.

Kathleen Florence Brady died November 1975 after a long illness. A graduate of St. Mary's Hospital School of Nursing Montreal, she entered the School of Nursing, McGill University and graduated with a Bachelor of Nursing degree in Public Health Nursing in 1951. She also received a Bachelor of Arts from Sir George Williams University and a Master of Arts from Teachers College, Columbia University.

For eighteen years she was a valued member of the administrative staff of the Montreal Branch of the Victorian Order of Nurses. Through her leadership the VON hospital liaison was established, the first such liaison program in Canada. In 1963 Brady joined the teaching staff at the School of Nursing, McGill University on a part time basis while continuing at the VON part time.

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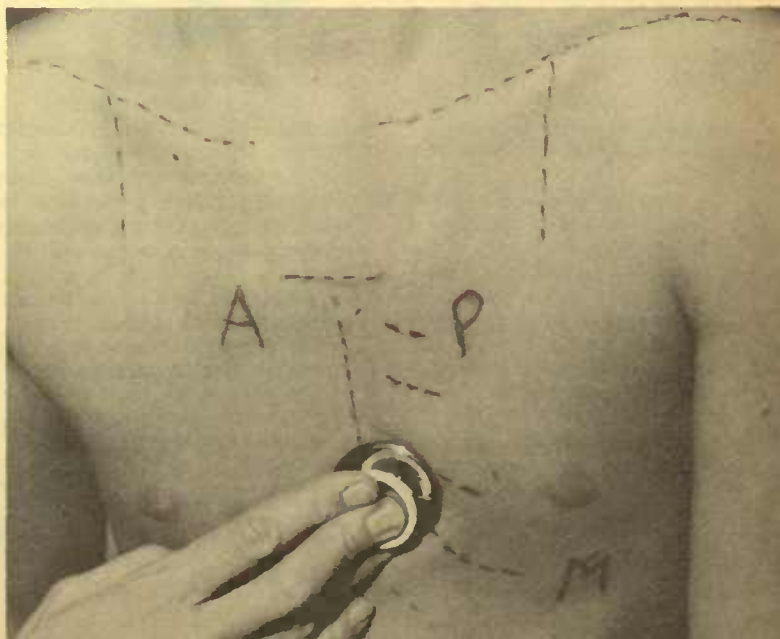
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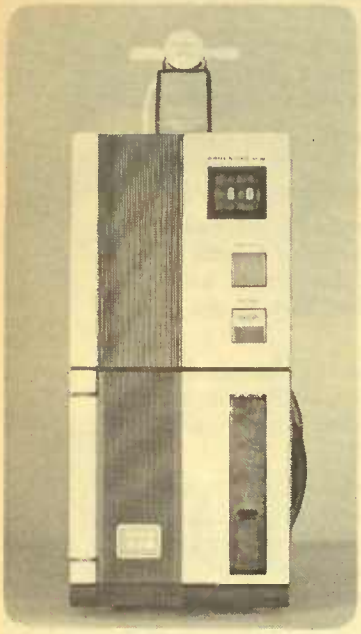
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For information, write: Tower Products, Inc., 1919 S. Butterfield Road, Mundelein, IL 60060 U.S.A.

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Hot or cold pressure may be applied with the Posey Insert Adaptor.

For information, write: Enns and Gilmore, 2276 Dixie Road, Mississauga, Ontario, L4Y 1Z5.

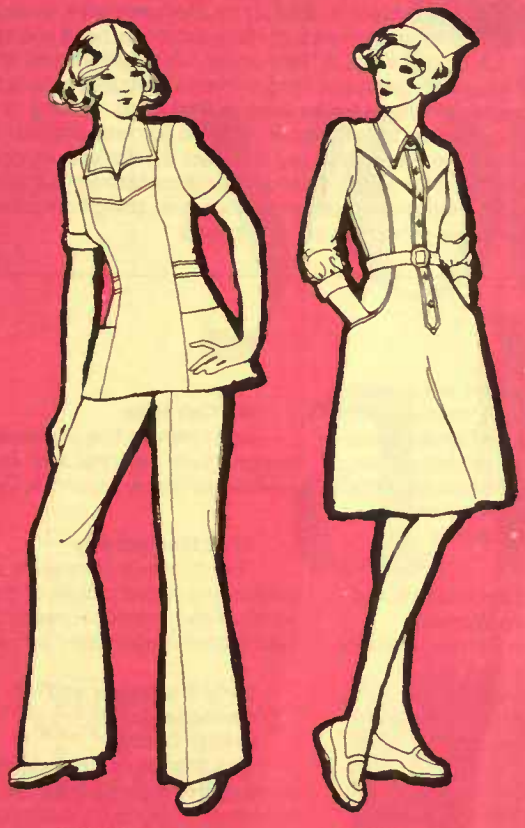
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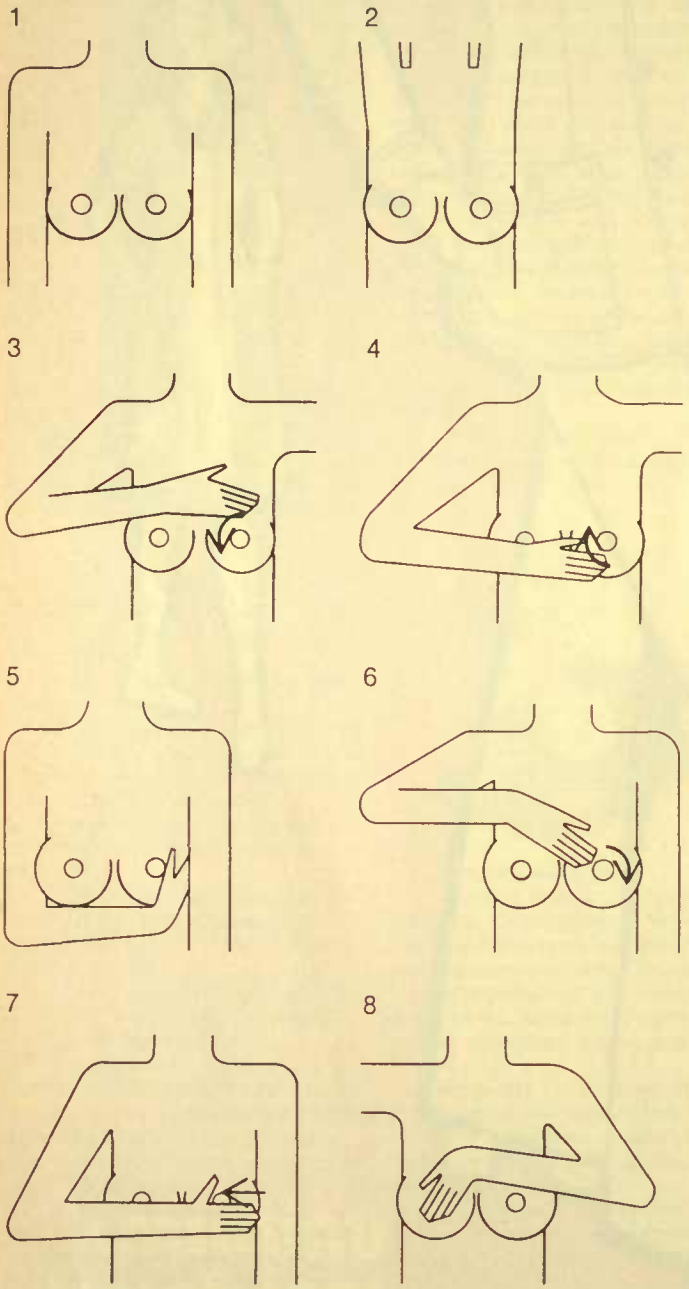
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Pamphlets on breast self-examination are available free of charge from your local office of the Canadian Cancer Society. Illustrations (reproduced at left) and captions give step-by-step instructions for monthly BSE. 1) In front of mirror, with arms relaxed at sides, examine breasts carefully for changes in size, shape, skin texture and discharge or change in nipples. 2) Raise arms over head and look for the same things. 3) Lie on bed with left hand under head. With fingers of right hand held together flat, press gently but firmly with small circular motions to feel the inner, upper quarter of left breast for lump or thickening, starting at breastbone and going outward toward nipple line. Also feel area around nipple. 4) With same pressure, feel lower, inner part of breast. 5) With left arm down at side, feel under armpit. 6) Feel upper, outer quarter of breast from nipple line to where arm is resting. 7) Feel lower, outer section of breast, going from outer part to nipple. 8) Repeat entire procedure on right breast.

Films

The following films are available on loan, free of charge, from your local office of the Canadian Cancer Society. A catalogue is also published listing these and other films available from the Canadian Cancer Society. All films are 16mm. and in color.

Breast Self-Examination and Time and Two Women
This 21-minute film demonstrates the technique of breast self-examination and explains the importance of the Pap smear in cervical cancer detection.

Assignment
A 20-minute film concerning a cured cancer patient and her daughter. It is a fast-paced educational film with a humanistic touch.

The Elusive Enemy
A 15-minute general film stressing prevention, detection and treatment of the major sites of cancer.

To Take A Hand
An 18-minute film emphasizing a positive, helpful approach to cancer nursing and discussing the need for the nurse to understand her own emotions about cancer before she can relate to the patient.

Recovery After Mastectomy
This 16-minute film presents, from a patient's viewpoint, the emotional strain experienced after mastectomy surgery and the help given by a mastectomy visitor.

We Can Help
An 11-minute film presenting the services, both personal and practical, available to cancer patients in Ontario.

After Mastectomy
This 20-minute film gives a medically-oriented picture of the physical and emotional needs of the patient after mastectomy surgery.

Early Diagnosis and Management of Breast Cancer
This 34-minute film depicts the signs of breast cancer and the essentials of thorough examination, and emphasizes detection in the early stages. Indications for mammography, hormone therapy, and chemotherapy are covered. A positive approach to prothesis, rehabilitation and follow-up is presented.

Books

A Cancer Source Book for Nurses
This is a valuable source of current information regarding most areas of cancer — its pathogenesis, diagnosis and treatment. It discusses the unique role of nurses in caring for the cancer patient. An excellent bibliography of current cancer literature is also included. Published by the American Cancer Society, 1975, and available free of charge from your local office of the Canadian Cancer Society.

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Books

Nursing Care of the Alcoholic and Drug Abuser by Pamela K. Burkhalter. 297 pages. New York, McGraw-Hill, 1975.
Reviewed by Joan Anderson, Assistant Professor, School of Nursing, University of British Columbia, Vancouver, B.C.

This book is divided into three parts: Part I discusses alcoholism, and the nursing care of persons who abuse alcohol; Part II is concerned with the nursing care of persons who abuse drugs; and Part III focuses on the rehabilitation of persons with these problems. Ideas about future nursing education, research and practice are also included. The material is systematically organized and clearly presented.

The author favors the disease concept of alcohol and drug abuse. She comments on some of the sociocultural aspects and briefly outlines major theories of causation. However, these tend to be summary statements rather than thorough sociocultural analyses.

The book lacks well developed theories and interpretations. Some major statements are not clearly documented, e.g., on page 13 no reference is given for the key paragraph — "Dependency — Independency," despite the sweeping and vague nature of the hypothesis about the alcoholic personality suggested.

The book lacks theoretical discussions but it still provides factual information in a concise format. Various treatment approaches are reviewed, that could provide a useful source of reference. The brief outline of the effects of alcohol leaves the reader with a good understanding of the physiological consequences of its abuse.

An overview of nursing care in a variety of settings is presented. Guidelines for assessment components and nursing care plan format with nursing approaches necessary for achieving identified goals are outlined. The nursing assessment considers the physical, psychological and social needs of the client.

Although the author acknowledges the possible need for referral services in relation to social problems, the nursing care plans for persons in the inpatient settings lack developed guidelines for family involvement. The focus is on the identified patient.

Family involvement is discussed at the community level of intervention. Granted, family interventions may not be regarded as the primary focus in the inpatient setting, but it could be argued that this should be an integral part of nursing intervention regardless of the setting. It seems to merit more consideration than that given by the author, particularly in relation to the psychiatric setting. Apart from this, the material is highly instructive.

Two of the more important concepts that Burkhalter emphasizes are nurses' attitudes toward the person who abuses alcohol, and education of nurses who care for persons with alcohol and drug abuse problems.

Research has shown that nurses' attitudes are usually characterized by ambivalence, but that extra educational preparation results in more positive attitudes. Because the nurse's attitude has a direct relationship to the type of care that the client receives, recognition and change of negative attitudes, are imperative in caring for persons with such problems.

The author makes recommendations for future trends in nursing education that would enhance the knowledge and skills of practitioners working with persons who abuse alcohol and drugs. She also discusses the interrelationship among, and the interdependence of nursing education, nursing research, and nursing practice.

The book is practical, if somewhat limited in theoretical depth. It could be a useful source of reference to students and practitioners in various settings.

A Summary of Integrated Nursing Theory by Sandra B. Fielo. New York, McGraw-Hill,1975. 186 pages.
Reviewed by Charlene Deffenbacher, R.N., M.S., Curriculum Development Instructor, School of Nursing, Royal Jubilee Hospital, Victoria, B.C.

The table of contents of this book will excite any nurse who is trying to pattern her approach to nursing care on a nursing model. One regards with great anticipation the emphasis on basic needs, anxiety, and growth and development in the Mental Health section, and the use of Stress and Adaptation as a conceptual basis for dealing with pathophysiology. Major Health Problems are grouped under socioenvironmental problems, problems of hypoxia, neoplasm, cell nutrition and elimination of wastes, and deal with conditions that are medically classified. The size of the book makes it obvious that in-depth content cannot be presented, but one hopes the text will provide, as stated in the Preface, a basis for understanding "the interrelationship of mind, body and environment" and will "help eliminate the separateness and fragmentation created by the artificial collection of contents into specialty areas, e.g. pediatrics, obstetrics, psychiatry."

Unfortunately, my expectations of this book in regard to the interrelationship of mind, body, and environment were not realized. Portions of the Stress and Adaptation section discuss disease causation in psychodynamic terms, but care of these diseases is medical-model oriented. Discussions that would tie the diseases together under the conceptual headings were inadequate or omitted. Concepts of disease prevention to increase the individual's repertoire of coping behaviors were not included. Models for nursing individuals with maladaptation disorders were not present; pathophysiology is discussed but this cannot be the sole theoretical base for nursing care. In summary, the book is not well-developed in terms of concepts for nursing, nor is it's theoretical approach as ecologically-based as one might expect.

The strength of the book is that it does discuss disorders under conceptual headings, with obstetric, pediatric, medical, and surgical conditions brought together. For example, the section titled "Problems of Hypoxia" discusses hemorrhagic conditions related to pregnancy, congenital heart disease, sickle cell anemia, myocardial infarction and other disorders. This pattern of intermixing the "specialty areas" is consistent throughout the book and merits definite praise.

If using this as a textbook, the nurse educator would need to examine it thoughtfully in relation to the student population. The terminology is relatively sophisticated in terms of reading levels and knowledge of the biological sciences. Good specific examples are included, however, which could assist the student to relate the terms to a particular condition. The amount of detail given about each disorder might be overwhelming to the nursing student, causing her to miss the overall concept. The book might be of value in post-basic nursing education, since it could serve as a review of disease conditions while laying groundwork for discussions of the concepts basic to all nursing care. Canadian nurse educators would also want to evaluate the book carefully since it is totally American in its orientation, with no mention of other countries and their health problems.

Care of Patients with Emotional Problems by Delores F. Saxton and Phyllis W. Haring. St. Louis, The C. V. Mosby Company, 1975. 104 pages.
Reviewed by Ken Green, Teacher, Algonquin College School of Nursing, Ottawa.

The authors of this text have treated the material in a very easy-to-understand style. They have divided the text into four parts — The Emotional Development of Man, The Relationship Between Physical Illness and Emotional Problems, Patients with Emotional Disorders, and Patients with Functional

sychotic Disorders — and have ucceeded in making each part elevant to the here-and-now of atient care. Although each chapter is elatively short and touches only the urface of a particular issue, it is ompleted with "study questions" that elp the student to review the concept r approach presented.

The organization of the first part f the book helps the student nderstand that all behavior, ncluding one's own, has meaning, nd that when the meaning is nderstood, a more therapeutic pproach to patient care can be lanned.

Parts II and III explain the elationship between physical illness nd emotional problems, and present pecific approaches for dealing with ome of these problems. These parts lso remind the student that many atients who may be suffering from hese problems will be found on the ards of general hospitals.

The final part of the text deals pecifically with some of the major ental disorders and provides pproaches that can be utilized in the sychiatric setting.

Although the text was written primarily for a specific group — practical nurses — I believe that other students will find selected chapters,e.g,Tools Utilized in Psychiatric Nursing helpful for discussion.

Biological Aspects of Human Sexuality by Herant Katchadourian and Donald Lunde. New York, Holt, Rinehart and Winston, 1975. 174 pages.
Reviewed by Barbara Reilly, R.N., B.A., Instructor, Royal Jubilee Hospital School of Nursing, Victoria, B.C.

Biological Aspects of Human Sexuality by Doctors Katchadourian and Lunde is an extraction of six chapters from their broader text, *Fundamentals of Human Sexuality* (2ed, c1975).

Biological Aspects of Human Sexuality essentially points out that "Biology is the bedrock upon which sex is based;" however, "there is more to human sexuality than biology." Katchadourian and Lunde in their six chapters, manage to cover the significant aspects of the anatomy and physiology of sexual function as well as pregnancy, contraception and sexual disorders (disease-oriented). It was refreshing to see discussed the sexual responses or reactions of the elderly as well as those of the younger age groups.

In general, the book presents well-organized information and research without bias and it would be meaningful reading for those less sophisticated in their knowledge of human sexuality.

Another attractive feature is that, throughout the book there are illustrations and brief discussions of the cultural variations that exist in the area of human sexuality.

In summary, *Biological Aspects of Human Sexuality* would seem of interest to any practicing nurse in the hospital or community. Certainly, it should find a place in any nursing school library and would give the student nurse a good core of knowledge upon which to build. This book would also seem of special interest to those involved in planning or offering a course in human sexuality in their nursing curriculum.

The only drawback of this book is that where budgeting has to be seriously considered, the broader text *Fundamentals of Human Sexuality* would be a wiser investment.

A Pediatric Play Program by Pat Azarnoff and Sharon Flegal. 102 pages. Springfield, Ill., Charles C. Thomas, 1975.
Reviewed by Jane Grinnell, Child Life Worker, Children's Hospital of Eastern Ontario, Ottawa, Ontario.

A Pediatric Play Program is a clearly written guideline for setting up a therapeutic play program for the hospitalized child. The book considers new and old hospital facilities, available materials, sample programs, staff qualifications, departmental guidelines, and negative and positive reactions to a therapeutic play program.

More pertinent, however, the book stresses the overall importance of such a program, in calming the separation anxieties of the child, in helping the child adjust to a particular problem, and in ensuring the continuing intellectual and emotional growth of the hospitalized child.

It lists types of activities which can be adapted to the hospital setting: large and small group games, crafts, special events projects, etc. A useful addition to this section of the book would have been a list of multiple activities, suited to the various age groups or medical problems in the hospital, with explanations as to why these activities are so appropriate.

The book clearly states that children's needs cannot be met by a program or facilities alone. To be successful, such a program must have input, acceptance, and participation from all areas of the hospital personnel. It suggests that it is people with positive attitudes who, through a well-designed program, can provide the warm emotional environment in which children can relax and grow.

A Pediatric Play Program is well worth reading by all those involved in a pediatric ward or hospital, as it provides guidelines, sparks new ideas, and reinforces the committments to the emotional well-being of the hospitalized child.



Library Update

Publications recently received in the Canadian Nurses' Association Library are available *on loan* — with the exception of items marked **R** — to CNA members, schools of nursing, and other institutions. Items marked **R** include reference and archive material that does *not* go out on loan. Theses, also **R**, are on Reserve and go out on Interlibrary Loan only.

Requests for loans, maximum 3 at a *time*, should be made on a standard Interlibrary Loan form or by letter giving author, title and item number in this list.

If you wish to purchase a book, contact your local bookstore or the publisher.

Book and documents

1. American Nurses' Association. *Facts about nursing 74-75.* New York, 1976. 237p.
2. Barstow, Ruth Elizabeth. *Coping with emphysema.* San Francisco, Ca., University of California, c1973. 143p. (Thesis — California)
3. Bergesen, Betty S. *Pharmacology in nursing,* by . . . and Andres Goth. 13ed. St. Louis, Mosby, 1976. 752p.
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6. Bristow, Opal. *Discharge planning for continuity of care,* by . . . et al. New York, National League for Nursing, c1976. 144p. (League exchange no. 112)
7. Brown, Joan C. *How much choice? Retirement policies in Canada.* Ottawa, Canadian Council on Social Development, 1975. 285p.
8. Bureau d'informatique dans le domaine de la santé. *L'ordinateur au service de la santé canadienne; catalogue et descriptions, v. 2, no 2.* Ottawa, 1975. 226p.
9. Burke, Shirley R. *The composition and function of body fluids.* 2ed. St. Louis, Mosby, 1976. 114p.
10. Campbell, Alastair V. *Moral dilemmas in medicine; a course book in ethics for doctors and nurses.* 2ed. Edinburgh, Churchill Livingstone, 1975. 212p.
11. Chater, Shirley, *Introduction à la recherche infirmière.* Genève, Organisation mondiale de la Santé, 1975. 36p. (OMS Pub. Offset no 14)
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20. Dison, Norma Grenler. *Simplified drugs and solutions for nurses; including arithmetic.* 6ed. Saint Louis, Mosby, 1976. 110p.
21. *Equity in health services.* Edited by Ronald Andersen, Joanna Kravits and Odin W. Anderson. Cambridge, Ballinger, c1975. 295p.

(continued on p. 58)

Calendar

June 21-23, 1976
Canadian Nurses' Association annual meeting and convention to be held at Hotel Nova Scotian, Halifax, Nova Scotia. Theme: The Quality of Life.

June 20 - 25, 1976
InformACTION 1976, annual conference of the Canadian Foundation on Alcohol and Drug Dependencies to be held in Toronto. Information from: Conference Manager, Informaction, 33 Russell Street, Toronto, Ontario M5S 2S1.

July 19 - 24, 1976
Congress of the International Federation for Home Economics to be held at Skyline Hotel, Ottawa. Theme: "Life, not just Survival." Information from: Linda M. Stepenoff, IFHE Congress Chairman, Suite 216, 56 Sparks Street, Ottawa, Ontario K1P 5A9.

July 2 - 3, 1976
Saskatoon City Hospital Class of 66 Nurses' Reunion. Information from: Dianne Minto, 413 - 112th Street, Saskatoon, Sask. S7N 1V7.

July 21 - 24, 1976
Conference on Behavior Modification in the Community to be held at the Winnipeg Inn, Winnipeg. Sponsored by the Manitoba Behavior Modification Association and the Behavior Modification Association of Sao Paulo, Brazil, with the assistance of the Continuing Education Division. Information from: Continuing Education Division, University of Manitoba, Winnipeg, Manitoba.

August 9 - 12, 1976
International Symposium on Sex Education and Therapy to be held in English in Stockholm, Sweden. *For information, write: Head, Swedish Institute for Sexual Research, Kungsgalen 15, S-111 43 Stockholm, Sweden.*

August 28 - September 3, 1977
World Congress of Psychiatry to be held in Honolulu, Hawaii. *For information, write: Congress Coordinator, VI World Congress of Psychiatry, c/o American Psychiatric Association, 1700 — 18th Street N.W., Washington, D.C. 20009, U.S.A. Housing and travel arrangements available through: Travel Consultants, Inc., 1025 Connecticut Ave. N.S., Washington, D.C. 20036, U.S.A.*

September 2 - 22, 1976
International congress on child abuse and neglect to be held in Geneva. Information from: Prof. P.E. Ferrier, University of Geneva, Department of Pediatrics, 1211 Genève, Switzerland.

September 19 - 20, 1976
American Academy of Medical Administrators 19th annual convocation and annual meeting at the Sheraton Hotel, Dallas, Texas. *For information, write: Noel Barber, AAMA, 6 Beacon Street, Boston, Mass. 02108.*

September 30 - October 2, 1976
Third annual workshop, professional health workers' section, Canadian Diabetic Association, to be held at Chateau Halifax, Halifax, N.S. Information from: Bev Cain, Compartment 15, R.R. 1, Redbank Road, Lower Sackville, N.S., B4C 2S6.

October 18 - 22, 1976
Course in "Practical Rehabilitation Techniques" at the Calgary General Hospital offered by the Department of Physical Medicine and Rehabilitation and the Department of Nursing Service. Information from: Director of Physical Medicine and Rehabilitation, Calgary General Hospital, 841 Centre Avenue East, Calgary, Alta. T2E 0A1.

October 26 - 29, 1976
Ontario Occupational Health Nurses Association annual conference to be held at the Park Hotel, Niagara Falls, Ontario. Information from: Anna L. O'Brien, Publicity Chairman, OCHNA, 320 Queenston Rd., St. Catharines, Ontario.

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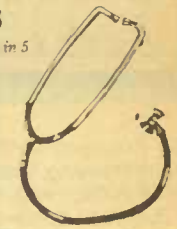


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Library Update

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Pamphlets

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no. 163 Hymes, James L. *Three to six: your child starts to school.* 28p.
no. 239 Ross, Helen. *The shy child.* 20p.
no. 254 Neisser, Edith G. *Your child's sense of responsibility.* 28p.
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52. Chagnon, Monique. *PRN 74; projet de recherche en nursing,* par . . . Lise Marie Audette, Louise Lebrun et Charles Tilquin. Classification des malades en pédiatrie. Montréal, Hôpital Ste-Justine, 1975. 227p. **R**
53. College of Nurses of Ontario. *Nursing education and registration 1974. Statistical report.* Toronto, 1975 46p. **R**
54. Lavoie, Denise Samson. *Étude de vingt situations d'échange entre l'infirmière et la famille du patient hospitalisé en milieu psychiatrique.* Montréal, 1974. 60p. (Thèse (M. Nurs.) — Montréal) **R**

Audio-visual aids

55. Institut canadien du film. *Catalogue des films sur les sciences médicales disponible de la cinémathèque nationale scientifique.* Ottawa, 1972. 144p.
56. Barstow, Ruth Elizabeth. *Coping with emphysema.* San Francisco, Ca., University of California, c1973. 1 reel. (Thesis — California)

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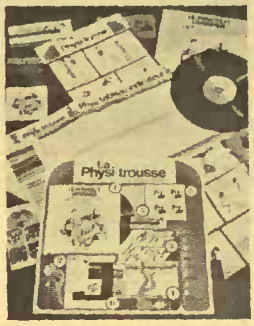
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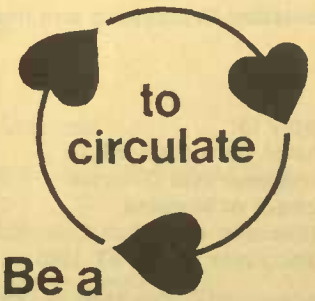
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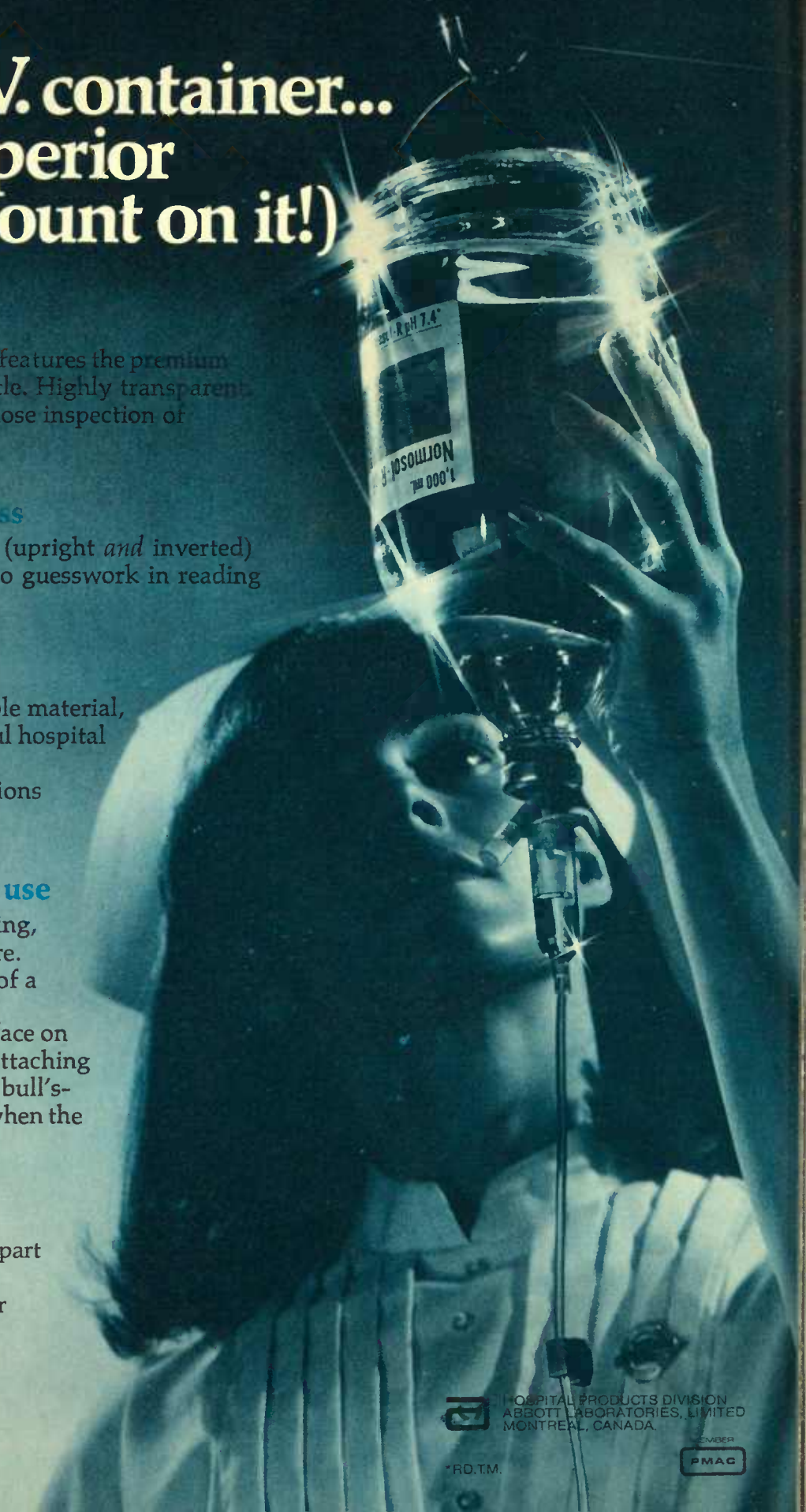
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The official journal of the Canadian Nurses' Association published monthly in French and English editions.

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There is a special challenge that faces the nurse who is a member of the occupational health team. Author Miriam Hayman describes that role this month in an article that begins on page 36. On the cover, occupational health nurse Nadine Franks bandages the hand of a worker at the Toronto brewery where she works. This photo and the ones that accompany the article are by Suzanne Emond of Toronto.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses' Association.

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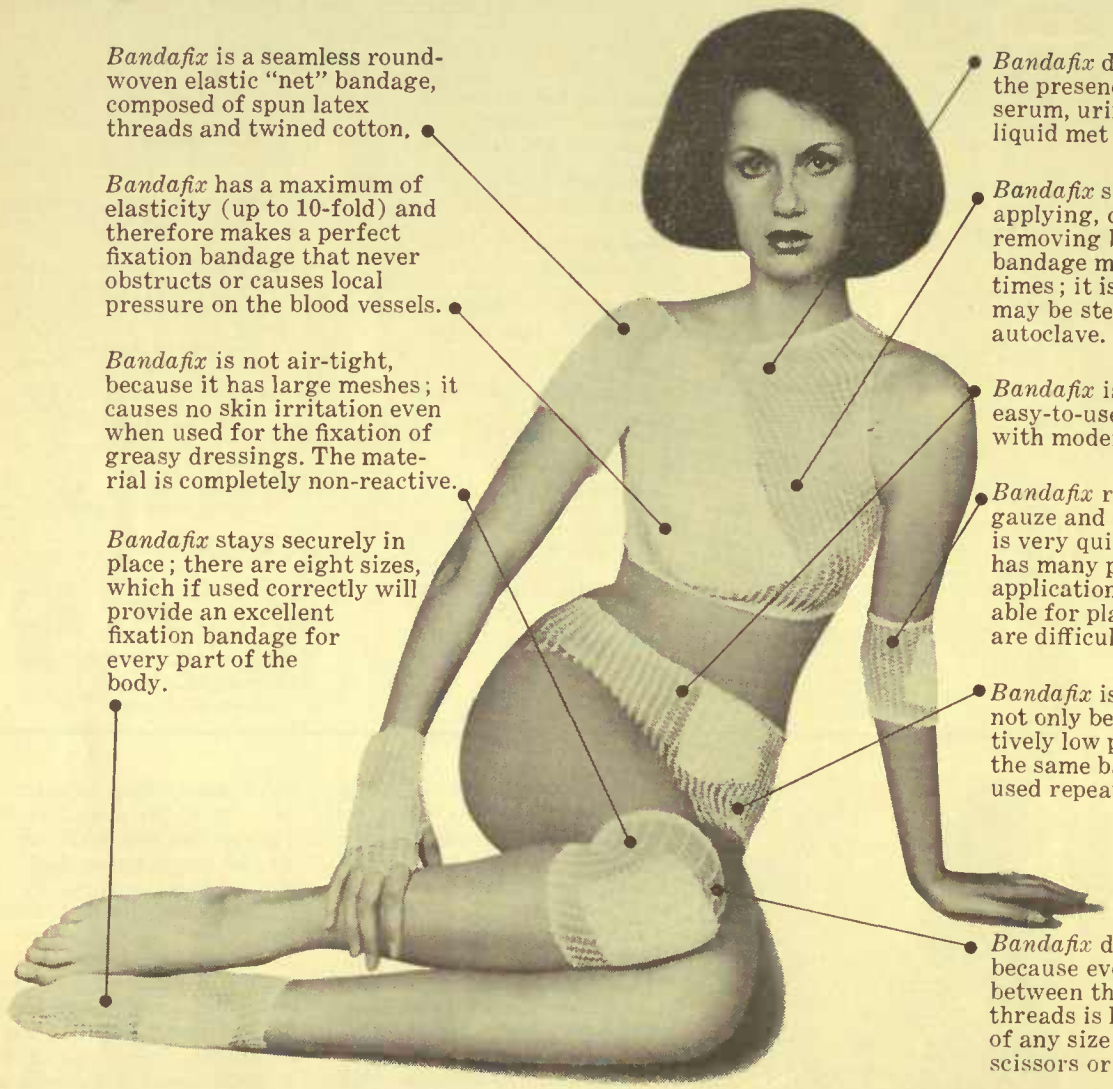
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Perspective

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Most associations regard their annual meeting as an important part of this democratic process. This is the chance for those who are committed to the advancement of their profession to get together to express dissatisfaction with existing standards, policies and practices. It is also the time when individuals can put their ideas before a group of their peers and debate the validity of their viewpoint. For the elected executive, it is the time when they have the right to expect direction and guidance from the people they will represent over the next year or two years.

Annual meetings are like a finger held up in the air to test the direction of the wind. They are a relatively easy and efficient way to keep in touch with membership (and readers). That is why this year I plan to take in four of them, including our own national convention.

Having once worked for an association that in pre-austerity times was noted (not to say notorious) for the intemperance of its members at their annual get togethers, I have to say that what impresses me most about the meetings I have been to so far this year, is the concern and dedication of the nurses who attend them. There is warmth and hospitality — the chance to make new friends and meet old ones again — but the prevailing attitude is one of serious concern for the issues of the day. The audience is attentive when guest speakers address them. The resolutions exhibit a range of interests that speaks well for the developing self-image of the nurse. The study sessions are almost always packed to capacity.

In short, a great deal is accomplished in a relatively short space of time BUT, and it is a big but, I am often left with the uneasy feeling that much of what is accomplished is done without the full knowledge and understanding of all the members.

It's not that anyone is trying to hide anything. Usually, in fact, it's just the opposite. Most associations spend a big chunk of their budgets on trying to improve communications with their members. They phone, write letters, send telegrams, publish newsletters, bulletins and journals. They hold meetings and workshops and ask the nurses who attend to carry word back to the people they work with. And yet, in spite of all this effort, many individual members arrive at an annual meeting unprepared to give the guidance that the profession really needs.

Think about it before you agree to represent your chapter at next year's annual meeting. Begin now to find out what the issues are. Talk to your friends. Attend meetings. Read your provincial newsletter and your national journal. Study the problems. Do your homework and show up next year prepared to speak up knowledgeably on the issues that concern you. Become an informed member: you and your profession will both benefit!

— M.A.H.

Herein



Prenatal genetic diagnosis of serious genetic disorders and chromosome abnormalities in the unborn fetus has created new dilemmas and responsibilities for expectant parents and the health team alike. Medical developments have given parents a new and sometimes difficult choice. Dr. Noreen Rudd, (M.D.), and Betty Youson, (B.N., R.N.), of the Department of Genetics, Hospital for Sick Children, Toronto, discuss some of the problems attending prenatal testing in next month's issue of *The Canadian Nurse*.

Central venous pressure monitoring is one of the most significant advances in the management of patients suffering from shock, chest injury or major trauma. Nurses need to be aware of this procedure and the specific nursing responsibilities involved since CVP is used with greater frequency in all acute care settings. In this issue, Gloria Kay and Patricia Kearns describe the "how to's" of CVP monitoring in a feature article that begins on page 15.

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The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

Input

Time to take a stand

I am angry and frustrated! I am angry over recent events that have affected my profession, (nursing) and I am frustrated by my seeming powerlessness to change or even have a say in these events.

I never cease to be amazed at the nature of nurses. We are indeed a classic example of conditioning. We are docile, well-mannered, respectful of authority, dedicated and above all, we OBEY! I have been waiting in vain to hear or read some protest from Alberta nurses re the budget cutbacks for hospitals. None have been forthcoming. Therefore I wish to go on record as one nurse crying in the wilderness "I protest."

The cutbacks have seen reduction of staff. If it required X number of R.N.'s and ancillary staff to give adequate supervision and professional care to X number of patients 6 months ago, how can it now be said to require less? When the restraints were announced I don't think we nurses truly realized the full import of it. The Government had spoken! "Cut the budget" and we like the well-conditioned sheep we are scurried around to do just that, voicing no objection. We went right along with the directive and in the process of cutting the budget we have cut our own throats.

How do you suppose we will react as the full realization sinks in? I think the reaction of our spokesmen in our Provincial Association is a good indication of our reaction in general. Not one mild protest or objection has been heard on the part of individual or organized nurses. Perhaps there is no feedback to our organization. If this is so — what is wrong with us? We are at fault.

We nurses are indeed a bunch of sheep. Perhaps we are not even as smart as sheep, they at least have a leader and follow *HER* to the death!

Of course we can handle it! We've done it before, we diploma nurses, for years and years! The expanded role of the nurse is nothing new. Nurses have *always* expanded to fill the gaps without protest. So we know we can do it, but let us ask — "Why must we?" Do we blindly follow government directives without protest? Must we stand by and watch the Government wipe out in a few months what took nurses years to achieve?

It is a fact that an ounce of prevention is worth a pound of cure. The time for Alberta nurses to act is *now* to prevent further deterioration of professional nursing care. We must make our protests heard before the Government takes our silence and compliance for agreement. Let us, for once, present a united front, nurses and realize what affects one affects all, be we diploma or degree.

I for one am writing my Provincial Organization, Federal Organization, my M.L.A., our Premier, my Hospital District and anyone else remotely connected with this issue — what are you going to do?

— Maxine Enderton, Rotating Supervisor, Sarcee Auxiliary Hospital, Calgary, Alberta.

Creativity in the profession

I wish to congratulate the new editors for the many positive changes that have marked *The Canadian Nurse* in recent months. The zippy new format, the fine editorial comments under the "Perspective" heading and the increasing number of cogent articles — particularly those dealing with various dimensions ot nursing practice — are indeed welcome.

Equally important has been the encouragement of members to submit ideas and manuscripts for publication. In doing so, the editors are not only reinforcing the CNA's objective of promoting unity through its offical organ; they are also reminding us as readers that the success of such a journal depends on the contributions of its readers as well.

Thus to my nursing colleagues who are doing many exciting things we don't often hear about I would like to say: the editors have shown us their flying new colors. Now let us as readers put our creativity where our complaints have been and encourage one another to CONTRIBUTE!

— Judith K. Hindle, R.N., Willowdale, Ont.

Florence unfrocked

I have read and reread Pat Barr's letter, "Nightingale debunked" (March, 1976). Having taken R.N. training in England and immigrating to Canada some 17 years ago, I feel that I must answer simply because I agree with most of what Pat wrote.

The very first day of training we all stood up so nicely and took what in England is called the "Florence Nightingale Pledge." I wish I could remember it all but one thing stands out in my mind: that is, you do what the doctors and your superiors tell you. Don't ask questions — do as you are told — and all will go well. Young people were not really any different then than now — they didn't like the idea too much — and in all the history of English nursing it seems there had never been a more audacious crew of new recruits. But they couldn't dismiss a whole school and for three years we put up with them, or maybe they put up with us.

It seems looking back that we not only disagreed with the system but tried to outwit "Old Flo." Ladies we certainly were not. Rules were very rigid but for young people this is a challenge. We had a lot of jokes about "Old Flo." Many years have gone past and I have learned a lot. But the same old rules are still there and there are still some nurses who try hard to break them — when they believe that what they say or do is right. What happens to them? Barr is wrong in saying that there are no iconoclasts, intellectuals, rebels and mavericks in the nursing profession. They are there but to keep working they keep their mouths shut, agree with everything and go home after shift and cannot sleep because they know they should have spoken up or complained to the Association they belong to.

If they do, things get rough. The doctors you have delivered babies tor and stitched up lacerations for because they are too tired to get out of bed, and even the Director of Nursing, turns on you and finds some way to get you out of there fast. They are afraid you might speak out, particularly when something goes wrong and you refuse to do these things anymore. Nurses are not fired — they are just told to quit and nothing will be said.

But I for one won't give up all the years I have practiced. So, Pat, you want a rebel, an iconoclast and a maverick? Count me number one. According to Webster's Dictionary, maverick is a nonconformist or an unbranded steer — in cattle-raising areas a maverick is a calf that has lo his mother. They go to another cov and hope to be taken in — funny thir is, they usually survive.

I am angry that things don't change and that the new kind of nurs still goes along with "Old Flo." But, somebody tell me, "Where does th branded nurse find employment?"

— Valerie A. Wilson, New Denver, B.C.

Geriatric interest group

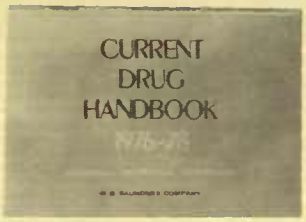
The Gerontological Nurses Association originated in April 1974. The initial group consisted of fourtee nurses gathered together to discuss the health care of the elderly person united by a common concern for th elderly in our society.

The main purpose of the Association is to draw people togethe who have an interest and a concern i this field. Our hope is to improve th standard of care of the elderly by sharing our ideas and experiences with others; by gaining further knowledge, awareness, and understanding of the elderly and the needs and in turn imparting this knowledge to the public and the elderly. Our aim is to improve the image of those professionally involve in the field of Geriatrics and Gerontology.

As we are a Nursing Association full membership is limited to Registered Nurses and Registered Nursing Assistants. However, as th multidisciplinary approach is so integral to the health care of the elderly, associate membership is encouraged. Our associate member include among others: occupational therapists, physiotherapists, doctors pharmacists and patients. We would like to hear from any other groups, o individuals, who share similar interests and can be reached at the following address:
Gerontological Nursing Association, P.O. Box 368, Postal Station K, Toronto, Ontario, M4P 2G7.

— Barbara Jensen, R.N. (president) Marjorie R. Wilcox, R.N. (education counselor).

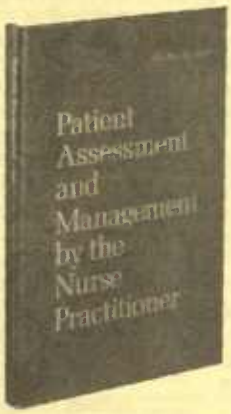
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CITY PROVINCE ZONE

Input

Grass roots action!

With reference to the article in the May issue, "The Handmaiden is NOT Dead," we thought that you might be interested in knowing that the fight continues at the grass roots level!!

Enclosed is a copy of an open letter that we sent some time ago to one of the pediatricians in an active treatment hospital. This was in reply to a note he had sent to the Unit Supervisor on a busy week end in which he had complained that no one made rounds with him. This doctor is now Chief of Pediatrics and his relationship with the nurses is good. He back slides occasionally but then so do we. Luckily for us he also has a sense of humor.

— Name withheld

Dear Dr. X:

In reply to your letter in which you complained bitterly about the staff on 4 West, please be advised that we, the nurses, are greatly disappointed in you. We had assumed that you were a young progressive medic with up-to-date ideas. Now you convince us that in your thinking you are back in the dark ages, when the nurse really was the doctor's handmaiden. Don't you realize that the modern nurse is vitally interested in patient care and not at all in doctor care? That is exactly where the nurses were on Saturday when you had to make rounds alone. They were taking care of your patients, as good Doctor's helpmates should.

In this age of specialized treatment and advanced technology you (the doctors) have placed an ever increasing workload on the nurses' already bowed shoulders. Now when it seems as if something must give, you state categorically that it isn't going to be you. Come now Dr. X., haven't you ever ordered a croupette to pacify or impress a mother? And who do you think does the chest physio that you order Q.I.D.? It sure isn't the physiotherapy department!! Well, hang in there, before long there may be a tape recorder at every bed side and all you will have to do is push a button, and a nurse will pop out with all the information it seems to be too difficult for you to acquire on your own, even after we went to all the trouble of simplifying it for you on one single day care sheet.

We are disappointed in you!! It is high time you moved out of your fathers' generation and into your own.

Feverishly yours,

4 West Staff..

An end to the benefits!

In "Frankly Speaking" some months ago, author Glenna Rowsell stated that readers' comments were welcome, and I have a few. After receiving some weeks benefits from the UIC, I have now been disentitled under what I feel is a very rigid interpretation of Section 25. Although I have an employment card and am on the "Casuals" list of one hospital, I cannot find permanent employment due to my advancing pregnancy (28 weeks). In fact I have not even been called for casual work. (My qualifications are apparently excellent as earlier in my pregnancy, had I not been pregnant, all three hospitals in the area would have hired me). At any rate, UIC has now disentitled me, stating I can and should find employment as a clerk, cashier or similar occupation. Is this truly fair? I feel that as I have paid for my training and have also paid UIC premiums during my working experience, I should not be channeled out of my profession because for a short time I am not employable in it. I intend to return to nursing after my baby is born.

At present I am appealing the UIC decision and also applying for positions as clerk or whatever I can find. I photocopied your article and sent it to the commission with my letter of appeal, as it expressed my frustration much more adequately than I could. I do not expect anything to be done and I really do not expect to win my appeal but it does help to know that the Canadian Nurses Association is aware of problems between the UIC and nurses.

— Patricia Bailey, RN, Saskatoon, Sask.

Sex education in the community

One of the responsibilities of the community nurse is to plan a comprehensive teaching program for her community on methods and responsibilities involved in the control of conception and spacing of children in the family.

My concern is that at such classes there is never any mention of the physical and emotional danger of promiscuity. Teenage high school students and others in this age group are encouraged to go to the doctor and learn the method best suited to their particular needs. One often hears remarks like the following: "If you use this or that particular device you can go out and have fun."

A recent film strip on venereal diseases, though very good in other ways, was singularly lacking in any direction in this matter. Viewers were urged to go for treatment, name contacts, get all available information, but not once was the point made of the part promiscuity plays in contracting these diseases. Emotional damage, guilt, and lasting effects on the personality were ignored.

We are told by the, so-called experts, that premarital sexually active teenagers need non-judgmental counseling and directed to be realistic about teenage sexuality but this supposedly modern approach does not help young people build stable healthy relationships. I am not suggesting we adopt a critical attitude. I have in mind the teaching, which is for the highest good of the learners and for best physical and emotional well-being. Neither am I suggesting that we withhold advice and teaching on birth control. On the contrary, I feel we must give sound teaching and up-to-date information on the subject. But let us also give them a way to greater happiness and fulfilment in sexual relations; a desire for something that is not cheap and easily obtained. Young people often have high principles and ideals. To teach responsibility in this area of life should be a paramount objective in our teaching of the subject.

— Margaret Wood, R.N., P.H.N., Uranium City, Sask.

Prepared childbirth?

I had a similar experience to tha described in "Matthew My Son," (March, 1976).

I practised prepared childbirth only to find, when I entered the hospital, that I had practised it incorrectly for four months. The prenatal classes did not prepare me adequately for childbirth especially when the "fetal monitor" was attache incorrectly. I was very frightened whe I saw the baby's erratic heartbeat. Even the case nurse thought for awhile that the baby was in danger, but finally was able to get the monito correctly connected.

The morning after delivery, I heard the babies in the hallway for morning feedings. I could not understand why my baby was not brought to me as it was ten hours sinc I had delivered; I did not even know where the bell was to call the nurse Finally, an hour and a half later, a nurse came to my room. When I asked why my baby had not been brought t me she replied that they were short-staffed.

It also distressed me that the nurses knew so little about breast-feeding. Each had her own ideas, or no ideas at all. Not until my fifth day in hospital did a nurse take a few minutes to get me nursing pads and to brief me on care of the breast. On the eighth day my breasts were so engorged my baby could not grasp the nipple. I asked the night nurse, for help and her answer was, "What do you expect me to do?" Thanks to the nursing assistant, who helped me express some milk so the baby could grasp the nipple, I did get my baby fed.

Life on the obstetrics ward was overwhelming and I was very happy when the day came to take my baby home. Now, six months later, I am still breast-feeding and find it a great joy; worth going through all the misgivings to finally feel secure in the "natural" way of feeding my baby.

— Barbara J. Charles, B.A., B.Ed., New Minas, N.S.

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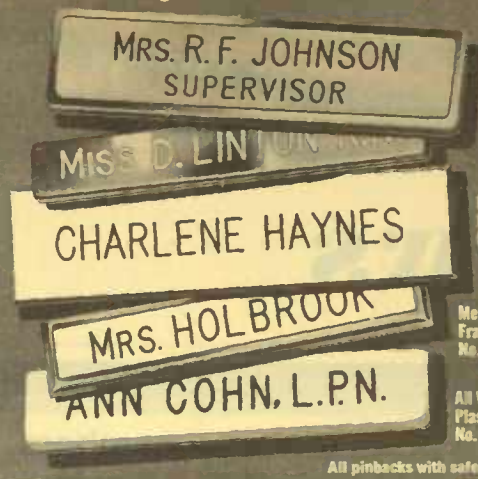
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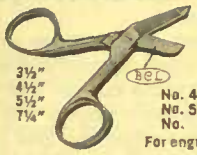
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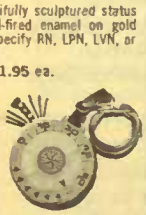
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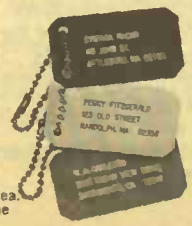
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News

RNABC admits student members, creates Labor Relations Division

Registered nurses in British Columbia have moved to broaden the membership base of their professional organization and, at the same time, to streamline the labor relations function of the association's services to its members.

Delegates to the 64th annual meeting of the Registered Nurses' Association of British Columbia in Vancouver in May, approved changes in the association's Constitution and By-laws making it possible for students attending an approved school of nursing to become members of their professional organization.

The decision is subject to amendments to the province's Registered Nurses Act and approval by the lieutenant-governor-in-council. It makes B.C. the first province to recognize students as members of their professional association. As "student members," they are eligible to serve as voting delegates and to be named to the Board of Directors.



Delegates also approved, subject to consent of the lieutenant-governor-in-council, the creation of an autonomous Labor Relations Division that will act as the collective bargaining agent for the province's nurses. The Division will operate within the framework of the RNABC Constitution and By-laws. It will be governed by a Labor Relations Council composed of bargaining units of the RNABC. The decision to alter the framework of RNABC labor relations activities came about as the result of a resolution passed at the last RNABC annual meeting and was taken to comply with existing labor legislation that prohibits "company-influenced or dominated organizations" (such as the RNABC) from acting as certified bargaining agents. The new Labor Relations Division held its founding meeting on the day following the close of the RNABC annual meeting.

Delegates to the annual meeting also approved a wide range of resolutions affecting health care services in the province and social and economic welfare of members of the nursing profession. One of the resolutions endorsed a Bill of Consumer Rights in Health Care. This includes the right of people to be informed about: preventive health care, the structure of the health care system, the individual's own diagnosis and treatment program and specific costs of procedures, services and professional fees.

The Bill would protect the right of an individual to maintain the confidentiality of his health records, to refuse experimentation, "undue painful prolongation of life or participation in teaching programs" and the right of the adult to refuse treatment, "to die with dignity."

Under the terms of the resolution, nurses also endorsed the right of the patient to participate in decisions affecting his health, through consumer representation at each level of government and with health professionals and personnel involved in his direct health care.

Other resolutions approved by the delegates urge the B.C. government to enact legislation that would require supervisors of municipal playgrounds to possess a recognized first aid certificate and would also compel drivers involved in motor vehicle accidents to have blood alcohol samples taken if requested by the police.



Anthropologist, Dr. Elvi Whittaker, at the mike.

Is nursing a professional ghetto? Are nurses members of the 'professional third world'? Are some parts of the nursing world so alienated that members regard themselves as an 'oppressed majority'? These were some of the questions raised by Dr. Elvi Whittaker, associate professor of anthropology at the University of British Columbia, when she spoke to delegates at the most recent annual meeting of the BC nurses' association. Dr. Whittaker, who is co-author with Virginia Oleson of "The Silent Dialogue: A study in the social psychology of professional socialization" warned her audience that, since she is not a nurse, she did not intend to provide definitive answers but would attempt to present the facts in the light of her own experience and let her audience judge for themselves.

A series of dramatized real-life situations, satirizing the powerlessness of nurses under some conditions, set the stage for an examination of the issue. In these skits, association members acted out typical behavior patterns of the oppressed, including reluctance to accept responsibility, sense of dependence and lack of self-determination, as they might be found in nursing.

In her talk, Dr. Whittaker also looked at the self-concept of the oppressed and the cultural and structural themes in society that support this arrangement. She reminded her audience that "the powerless themselves support the perpetuation of the system by accepting their helplessness and acting accordingly."

Reaction to the ideas expressed by the speaker came from two directions: each member of a panel of five nurses representing various areas of practice spoke briefly on her own personal feelings and, later, members of the audience took turns at the microphones. Opinions on the central issue of whether nurses are in fact members of an oppressed group in society varied widely and included agreement, surprise, resentment and denial. Panel members were: Elizabeth Cahill, staff nurse, Burnaby General Hospital, Burnaby; Julie Downey, student nurse, Cariboo College, Kamloops; Gerry-Lou Miller, staff nurse, Central Vancouver Island Health Unit, Duncan; Gloria Parker, supervisor, Glendale Lodge, Victoria; and Criss Rogers, instructor, Faculty of Nursing, U.B.O., Vancouver.



Criss Rogers fields a question from the audience.

Photos by Attwood

Quality assurance program to get underway in B.C.

Starting this Fall, B.C. nurses will have the opportunity to find out for themselves what "quality assurance" can mean in their own practice setting. That's when the first of a series of regional workshops organized by the RNABC will get underway throughout the province.

The workshops are the first tangible steps in the "Quality Assurance Program" which promises to be the focus of RNABC activities in the immediate future. Emphasis on quality assurance is a reflection of the shift in priorities from nursing standards to a system intended to evaluate nursing performance *(process)*, results of care *(outcome)*, and agency resources *(structure)* simultaneously. A quality assurance program not only permits evaluation of care using written, ratified standards, but it also initiates action to maintain or improve desirable standards of care.

The RNABC points out that for nurses in practice, administration, education or research, implementation of the system offers numerous advantages, including:

- clarification of job descriptions;
- direction of nursing practice;
- feedback about the quality of care;
- identification of learning needs;
- increased job satisfaction, and
- identification of the nurses' role as a consumer advocate.

Implementation of the program involves, along with the workshops, identification of "change agents" on a regional basis. These will represent various levels of nursing practice and nurses practicing in each area of the health care system . They will be available for consultation in each area. RNABC nursing services staff members will also be available for consultation and will assist in setting up workshops.

Standards of nursing care have been one of the B.C. association's chief concerns during the seventies. Between 1970 and 1974, committees drafted standards in the five specialty areas of nursing practice: emergency, extended care, intensive and coronary care, obstetrics and psychiatry.

In June, 1975, the Committee on Adoption of Standards held its first meeting. Members represented RNABC standing committees on Nursing Education and Practice, the Nursing Administrators' Section, the BC Continuing Nursing Education Committee and staff nursing. The name of the Committee was later changed to the Committee on Quality Assurance because members felt that quality assurance necessitates more than the statement and adoption of standards.

NLN and ANA approve plans for U.S. screening agency

A project for development of pre-immigration screening of nurses trained in foreign countries has been initiated by a joint board of trustees of the National League for Nursing and the American Nurses' Association.

Titled the Commission on Graduates of Foreign Schools of Nursing, the new organization will function as an independent, nonprofit body. The commission will develop and conduct a pre-immigration program to evaluate credentials and assess nursing and English language proficiency in order to provide reasonable assurance that nurses trained in foreign countries would be eligible for admission to the state licensing examination.

At a meeting in Chicago in May, the board approved a proposed schedule that could put the screening program in operation by the end of 1977. The cost of developing and maintaining the organization until it is self-supporting was estimated at approximately $100,000 — an investment to be shared equally by NLN, ANA and the Division of Nursing, HEW.

The project was prompted by government concern about increasing numbers of nurses who enter the U.S. in search of employment but fail to qualify for state licensure.

First NWTRNA Meeting Held in Yellowknife

The first biennial meeting of the Northwest Territories Registered Nurses Association was held in Yellowknife in April of this year. Its theme was "Emergency Nursing."

Dr. Masson, Director of the Emergency Department of the University of Alberta Hospital, gave detailed lectures on emergency treatment of burns, gunshot wounds, head injuries, stab wounds, and shock. Mrs. Saad, Director of Nursing of the same emergency department, spoke generally on emergency nursing, stressing the initial emergency care of patients based on identification of their most immediate needs. Dr. Covert and Mrs. Collins from Hay River, spoke on emergency cardiac treatment, while Dr. A.P. Abbot dealt with acute psychiatric situations.

The meeting brought members from many areas of the million and a half square miles of the Territories; from the Western Arctic and Tuktoyaktuk, to the Eastern Arctic; from Frobisher Bay, to the southernmost settlement of Fort Smith.

Huguette Labelle brought greetings from the Canadian Nurses Association and words of encouragement from Health and Welfare Canada. Dr. Helen Glass, Director of the school of nursing of the University of Manitoba talked about Continuing Education in the nursing profession.

The Convention was opened by Assistant Commissioner Mullins of the Government of the Northwest Territories. President Leone Trotter, President of the N.W.T.R.N.A. opened the general meeting and elections took place. Barbara Bromley of Yellowknife was elected president of the Association, and Sharon Collins of Hay River, president-elect.

The N.W.T.R.N.A. is the youngest of eleven members of the Canadian Nurses Association, its membership in the CNA dating from October of 1975.

Ontario offers courses in long-term care

Long-term care, with special emphasis on management of the elderly, is the subject of two new four-week programs being offered at Ontario's George Brown College in Toronto. The short courses are intended for teachers of diploma or continuing education programs on long-term care and are being held during June and July.

The courses came into being as a result of a resolution passed by members of the Registered Nurses' Association of Ontario at their annual meeting three years ago. Under the terms of resolution, the RNAO accepted as a priority "activities related to promoting standards of care and assistance to members engaged in long-term care settings."

Other association activites related to carrying out the terms of this resolution have included: conferences on care of the long-term patient; government submissions; assistance to individuals or groups of nurses and meetings with government representatives and appropriate associations.

An RNAO coordinating committee, composed of representatives from government and allied health organizations in long-term care, developed a proposal that the government initiate programs for registered nurses in long-term care. This proposal was presented to Ontario Ministries of Health, Community and Social Services and Colleges and Universities, in July 1974. The program is open to teachers who are registered nurses with university preparation and two years of teaching experience or equivalent, or registered nurses who have related consultant and management responsibilities.

Did you know

Men can have Pap tests, too! Dr. John F. Seybolt, director of the Papanicolaou Laboratory of New York Hospital — Cornell Medical Center, has pointed out that the Pap test can be used to detect cancers of the respiratory tract, lung, GI tract, GU tract, CNS, breast and the eyes.

News



Photo by Studio Impact, Ottawa

Five nurses from France were in Canada from May 13 to June 4 as part of their studies at the "École de cadres d' infirmiers et d' infirmières" in the regional hospital of Nantes. One of the objectives of the tour was to learn about nursing education and care in Canada. The tour took them to Kapuskasing, Hearst, and Timmins in northern Ontario where the five nurses were guests of RNAO members.

In Ottawa, the nurses visited several health centers and CNA house. The Canadian Nurses Association, in its role as the national representative of nurses' associations in Canada, serves in a liaison capacity for international visitors. While at CNA house, the nurses visited the Library where this picture was taken. From left to right are: Yvette Brillant, Marie-Louise Hébant, Jacqueline Flick, Jeannine Roussel, and Monique Daniau.

AIB Issues Bulletins on Compensation Guidelines

Seven technical bulletins on compensation to help bargaining agents and employers interpret the Anti-Inflation guidelines have been made available by the Anti-Inflation Board. The bulletins deal with:

- the definition of an employee;
- a guide to employers in determining the composition of employee groups;
- compensation plans;
- methods to be followed in determining base date for groups of employees;
- the application of the regulations to three types of employer expenditures required by federal or provincial legislation;
- retroactive compensation;
- amendment to the guidelines to permit employer increases in compensation of lower-paid employees above the permissible percentage increases for the group.

Copies are available at all district taxation offices in Canada as well as the Anti-Inflation Board's regional offices at Halifax, Winnipeg, Toronto, Quebec City, Montreal and Vancouver.

U of A graduate scholarship

A graduate scholarship, valued at $1,000., in recognition of the 50th anniversary of the schools of nursing of the University of Alberta and University of Alberta Hospital has been announced by the U. of A. Hospital Board. The scholarship recipient must be a graduate of the University of Alberta school of nursing and have been accepted as a full-time student in a recognized university for advanced nursing-related education at the Baccalaureate, Masters or Doctoral level.

Applicants will be evaluated on their potential for leadership in nursing and for contribution to nursing and the community, as well as their educational experience and references. Applications should be submitted to the vice-president — nursing, University of Alberta Hospital, 112 Street and 83 Avenue, Edmonton, Alta., T6G 2B7.

NBARN celebrates 60th anniversary

In June, Simone Cormier was re-elected president of the New Brunswick Association of Registered Nurses for a second year. Cormier is the director of nursing at Hotel Dieu Hospital in Campbellton, and a graduate of L'Ecole d'Infirmières St. Joseph and L'Institut "Deux Alices," Brussels, Belgium.

Other newly elected officers for the 1976-77 term are Judith Oulton, Fredericton, first vice-president; Sister Germain Preston, Moncton, second vice-president; and Lucille Gaulton, Saint John, honorary secretary.

The NBARN celebrated its 60th anniversary as the professional organization for the nurses of New Brunswick in June. At the annual meeting in Fredericton the anniversary theme was 'Today's Nurse - A Dynamic Professional.'

Swine flu attack

Canada has succeeded in obtaining commitments for 7.5 million doses of influenza vaccine, 6 million of monovalent A/Swine vaccine and 1.5 million of bivalent A/Swine and A/Victoria vaccine.

Acting on behalf of the provincial governments which will be undertaking immunization programs against Swine influenza this fall, Health and Welfare Canada and Supply and Services Canada have obtained firm commitments for vaccine from two different manufacturers and a commitment for a large supply from the United Kingdom. Discussions are in progress with a number of other foreign suppliers in order to obtain all the vaccine necessary.

Swine influenza is thought to be the same strain of flu blamed for 21 million deaths in the world pandemic of 1918 - 1919. It was isolated last February at Fort Dix, New Jersey, following the death of one recruit from influenza and pneumonia. The virus is expected to hit Canada in the fall at the beginning of "flu season" and, already, plans are underway for a massive innoculation program to immunize 11.6 million Canadians at an estimated cost of $70 million. Vaccinations will be administered by each province starting September 1. At present, Canadian health officials are carrying out a country-wide flu surveillance program to predict the course and intensity of the flu.

In its September issue, *The Canadian Nurse* will publish an article on the effects of Swine flu and the nursing care involved. Look for it! You may need to be prepared.

Did you know

The University of Alberta Hospital, Edmonton, has recorded Alberta's share of multiple births for the year. Over a thirty day period, beginning April 19, 1976, four sets of triplets were delivered. That's as many as are normally recorded at all hospitals in the province in a year. The birth of triplets usually occurs once in approximately 8,000 births.

Unit-dose drug distribution offers significant advantages

A national study has found that the unit-dose system of drug distribution can improve the level of pharmaceutical service in hospitals. It cannot, however, be expected to solve the problems of traditional systems automatically, and its introduction may result in cost increases.

Under the unit-dose system, hospital pharmacists provide all drugs in packaged, single doses ready to be administered by nurses. In most traditional systems, nurses obtain frequently used drugs from bulk floor stocks and receive others in individual patient prescriptions that normally contain a large number of doses.

The study was launched by the College of Pharmacy at the University of Saskatchewan and the Canadian Society of Hospital Pharmacists and supported by a $250,000 national health grant. Dr. Bruce Schnell, of the College of Pharmacy, directed the investigation, which was carried out over the last three years at four hospitals in different parts of Canada. He was guided by a research committee chaired by Professor Jack Summers, of the College of Pharmacy, and representing the Canadian Society of Hospital Pharmacists, the Canadian Nurses Association, the Canadian Medical Association, and the Canadian Hospital Association.

Dr. Schnell reported the results at the annual meeting of the Canadian Society of Hospital Pharmacists in Saskatoon recently. He and his colleagues found a significant change in work patterns when the hospitals introduced the unit-dose system. Pharmacists spent more time dispensing drugs for inpatients and providing information related to medications. Registered nurses, on the other hand, spent significantly less time on activities related to medications and some of the time saved appears to have been channeled into direct patient care.

Important errors such as administration of a wrong drug, an unordered drug, or a drug that has deteriorated were fewer under the unit-dose system. However, the study team found that pharmacies failed to pay enough attention to the accuracy and appropriateness of the volumes of liquids packaged in unit-dose to ensure the delivery of the dose ordered.

Both pharmacy and nursing personnel generally favor a unit-dose system "when asked to compare it selectively to a traditional system," and patients favor it because the single, packaged doses are "labeled and are more sanitary."

The study team identified personnel expenses as the greatest single factor in determining whether total costs go up or down under a unit-dose system. "Any increase in pharmacy staff would have a large effect on total cost *unless a corresponding reduction in nursing time occurred.*"

The report includes a series of recommendations on how to improve traditional drug distribution systems and how to implement the unit-dose system. It also recommends both professional and government encouragement for the adoption of the unit-dose system and urges follow-up studies to obtain more information on costs, on medication errors, and on longer-term experience with the unit-dose system; and to develop a model to aid in designing and budgeting unit-dose systems and in determining optimum staffing requirements.

New direction plotted for world health

Dr. Halfdan Mahler, Director-General of the World Health Organization, has called for a "drastic and fundamental rethinking of the relationships between communities and their health services." In his most recent annual report, *The Work of WHO, 1975*, he concluded that the most urgent health problems in developing countries are related to poverty, infection, malnutrition, environmental hazards and lack of accessible potable water. Because these health problems are so basic they are not likely to be solved by separate programs designed to control specific diseases or centralized services based on advanced health technology.

In the future WHO will be committed to a concept of health which includes economic and social development as well as medical care, and will set priorities according to the underlying causes of health problems.

Mahler also pointed out that many of the health care solutions of the industrial world are too costly and inefficient to be practical for developing countries. For this reason, WHO will continue to place strong emphasis on provision of primary health care as an integral part of national health services.

Notes on going metric

In a report to the federal Metric Commission, the Canadian Hospital Association has indicated that approximately 69 percent of the hospitals in this country converted to the metric system during 1975.

Results of a sample survey conducted by the CHA research and statistics department showed that another 12 percent of Canadian hospitals reported partial conversion to the metric system.

The CHA reports that since June 1975 not one Fahrenheit thermometer has been imported into Canada. The SI Metric Conversion Kit for Hospitals is available from the CHA at a cost of $5.00.

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Names and Faces



E.A. Electa MacLennan was honored by the presentation of a LL.D., Doctor of Laws, Honoris Causa degree by the Faculty of Health Professions, Dalhousie University at their spring convocation on May 13, 1976.

MacLennan, past president of the CNA from 1962 - 64, has had a full and varied nursing career. A graduate of the Royal Victoria Hospital School of Nursing in Montreal, she received her diploma in Teaching in Schools of Nursing from McGill University, and her M.A. in Public Health Supervision from Columbia University. She was National Office Supervisor for the Victorian Order of Nurses for the Maritimes and assistant director of the McGill School for Graduate Nurses before becoming the first director of the School of Nursing at Dalhousie.

Her active involvement in nursing spans to cover community health nursing, the realization of in-service education in Nova Scotia hospitals at a time when the need for such education was scarcely recognized, and the organization of the annual Nursing Institutes which serve to keep nurses informed of trends in health care.

She has represented Canadian nurses internationally at ICN conventions in Australia and in Geneva. She was a Board Member of the ICN from 1962 - 69 and in 1967, Canada awarded her a Centennial medal for her achievements.

Among her varied interests are a love of music, stamps and gourmet cooking. She is now retired from active nursing and lives in Brookfield, Nova Scotia.

Mildred Tuttle of Marshall, Michigan, a leader in the field of nursing died on April 2, 1976 at the age of 73.

Tuttle was affiliated with the W.K. Kellogg Foundation of Battle Creek, Michigan, for 36 years until her retirement in 1968. Over the years, the Foundation has been identified as a major private funding source for programs to improve nursing education and service. She was responsible for the Foundation's grant activities in this field. She was a leader in movements to prepare clinical nursing specialists and associate degree nurses in the United States, for the improvement of nursing leadership in Canada and for strengthening nursing education and the training of nursing auxiliaries in Latin America.

Her own nursing education was extensive including a B.N. in 1926 from Case Western Reserve University, M.A. from Vanderbilt University, M.S. in public health nursing, an honorary Doctor of Science degree from Wayne State University in 1955 and a citation for outstanding leadership in nursing by the National League for Nursing.

She served as a community nurse for four years and taught nursing, public health nursing and health education before joining the Kellogg Foundation.

Carol Beazley (B.Sc.N., Mount St. Vincent University) has been appointed nursing and planning officer with the Nova Scotia Emergency Health Services.

She has worked with the Victorian Order of Nurses, Hawker-Sidley at the Halifax shipyards, and has done medical nursing at the Halifax Infirmary. She has also had experience as a ship's nurse with the Canadian Coast Guard ship, Louis St. Laurent, and the Bedford Institute of Oceanography ship, Hudson.

Caroline A. Manley (R.N., St. Joseph's School of Nursing, Cornwall) of Berwick has been appointed director of nursing at the Winchester Memorial Hospital, Winchester, Ont.

She succeeds the late **Bernadette Legris.**

Jean Armstrong (R.N., Regina General Hospital School of Nursing, P.H.N. Dipl., University of British Columbia) has retired as regional nursing supervisor of the Moose Jaw — Assiniboia — Gravelbourg Health Region, following nearly 30 years of public health nursing service in Saskatchewan. She served as a nursing sister in the RCAMC during World War II.

Mary Pack, who made better treatment for arthritic patients a personal lifetime crusade, has become the first woman to receive the $50,000 Royal Bank Award. She was named 1976 recipient in recognition of her contribution to human welfare and the common good.

Pack is recognized as the moving force behind the founding of the Canadian Arthritis and Rheumatism Society (CARS), established in 1947 and represented today in every province. She founded and from 1948 to 1969 was executive director of the British Columbia division of CARS, the first provincial organization.

In announcing the award, the Hon. J.V. Clyne, chairman of the award selection committee, said: "The success of her efforts has benefited hundreds of thousands of arthritis sufferers and made Canada a world leader in research and treatment of the disease. As a result of her work, sufferers who 30 years ago could have been confined to bed from childhood are today receiving treatment that allows them to lead normal everyday lives."



Mary Pack is the 11th recipient of the Royal Bank Award and will be presented with the specially struck gold medal and a $50,000 cheque at a dinner in Vancouver on July 12. Her latest honor will be added to numerous accolades at home and abroad. She is a member of The Order of Canada and a recipient of the Queen Elizabeth Medal, a coronation commemorative award for outstanding contribution to the welfare of people of the British Commonwealth.



Lily M. Turnbull, chief nursing officer of the World Health Organization, retired after 23 years of service to that organization. Her first WHO post was as senior nurse educator/team leader with a nursing education project in Malaysia. She then was regional nursing adviser, Western Pacific Region until her appointment as chief nursing officer in 1969. A graduate of the Regina General Hospital school of nursing, she obtained her Bachelor of Nursing degree from McGill University, Montreal, and her Master of Public Health degree from The Johns Hopkins University school of hygiene and public health, Baltimore, Md.

Mary G. Smith (R.N., Ontario Hospital Hamilton and Brantford General Hospital; Nursing Unit Admin., Canadian Hospital Association) has been appointed assistant director of nursing at Welland County General Hospital, Welland, Ontario. She has been on staff in the emergency department of the St. Catharines General Hospital, and has for several years been associated with the Welland County General Hospital in an administrative capacity.

Clinical Wordsearch #1

H I K E C S C U L T E T U S U L A
A Y E C L V L R A O P N C G N E Y
P S P L O A I G P R R R I N A V M
P S A E E H P I A S E P T I C A O
E U I S R C S S R C O N A S O N T
N E N K S A T E O A P I E S L O C
D L L I U G L R T N U S R E O I E
I I A N T I B I O T I C C R S T T
C C P G U L O E M L L A N D T N S
I I A L R E S S Y E Y R A R O E Y
T T R E E U L C E R N T P C M T C
I Y O V S M C A T H E T E R Y S E
S L S I C I S E G L A N A S B I L
E A C N O I S U F S N A R T I D O
R R O E D A N A E S T H E T I C H
U A P T T U B E Y M O T C E L O C
M P Y S Y M O T C E R E T S Y H N

Solve the clues. The bracketed number indicates the number of letters in the word or words in the answer. Then find the words in the accompanying puzzle. The words are in all directions — vertically, horizontally, diagonally, and backwards. Circle the letters of each word found. The letters are often used more than once so do not obliterate them. Look for the longest words first. When you find all the words, the letters remaining unscramble to form a hidden answer. *(Answers page 41)*

1 Usually a mid-line abdominal incision *(10)*
2 Removal of the gall bladder *(15)*
3 Postoperative complication characterized by absence of bowel sounds *(9, 5)*
4 Temporary or permanent opening of large bowel on the surface of the abdomen *(9)*
5 A nasogastric tube *(6)*
6 Help in maintaining acid base balance *(12)*
7 A stitch in time might have saved nine of these *(7)*
8 Protective covering for a wound *(8)*
9 Free of infection *(7)*
10 Removal of the uterus *(12)*
11 A rubber or silastic tube used to drain the bladder *(8)*
12 A drug that relieves pain *(9)*
13 A drug used for preventing and treating infection *(10)*
14 The replacement of blood *(11)*
15 An abdominal binder used postoperatively to provide support *(9)*
16 May be caused by an accumulation of gas in the gut *(10)*
17 Pertaining to that gland situated below the stomach *(10)*
18 May be a barium swallow or barium enema *(8)*
19 A method of providing nourishment parenterally *(17)*
20 Inflammation of the vermiform appendix *(12)*
21 That portion of plasma less fibrinogen *(5)*
22 Usually used in addition to sutures to add strength *(5)*
23 A drug which may have a local or general effect in producing a lack of feeling or sensation or rendering a person unconscious *(11)*
24 Excision of the colon *(9)*
25 A mechanism for draining bile postop after removal of gall bladder *(5)*
26 Medication given before surgery *(5)*
27 What one doesn't feel when inebriated *(4)*
28 A condition characterized by pallor, clammy cool skin, rapid pulse, and decreasing blood pressure *(5)*
29 It's usually well centred; not a military base *(5)*
30 Pro re nata *(3)*
31 Motor vehicle accident *(3)*
32 Intravenous cholangiogram *(3)*
33 Nil per os. *(3)*
34 A technique of exploring the abdomen by using a scope *(11)*
35 Operating room *(2)*
36 Test done by nuclear medicine *(4)*
37 The plastic surgeon's territory *(4)*
38 Bathroom privilege. *(3)*
39 A localized erosion of mucosa by hydrochloric acid *(5)*
40 Between jejunum and ascending colon *(5)*
41 How you look with a haemoglobin of 7.4 gm. *(4)*
42 Tres in die *(3)*
43 Shortness of breath *(3)*
44 Omne die *(2)*
45 What's left of last year's incision *(4)*

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Calendar

July

"Life, not just Survival," Congress of the International Federation for Home Economics to be held at the Skyline Hotel, Ottawa, July 19 - 24, 1976. Information from: *Linda M. Stepenoff, IFHE Congress Chairman, Suite 216, 56 Sparks St., Ottawa, Ontario, K1P 5A9.*

Conference on Behavior Modification in the Community, to be held at the Winnipeg Inn, Winnipeg, July 21 - 24, 1976. Information from: *Continuing Education Division, University of Manitoba, Winnipeg, Manitoba.*

August

Ninth International Conference on Health Education will be held at the Skyline Hotel, Ottawa, Ontario, Aug. 29 - Sept. 3. Theme: "Health Education and Health Policy in the Dynamics of Development." For information, write: *Canada's Organizing Committee, Ninth International Conference on Health Education, c/o CHESS P.O. Box 2305, Station D., Ottawa, Ontario, K1P 5K0.*

Critical Care Nursing: an eight-week program offered five times a year, to those registered or eligible for registration in the Province of Nova Scotia. The next program begins Dec. 6, 1976 with an application deadline of August 30, 1976. For further information, contact: *Group Leader, Critical Care Program, Continuing Education, Victoria General Hospital, Halifax, Nova Scotia, B3H 2Y9.*

Continuing Education Course, "Fetal monitoring maternal -fetal medicine," to be held at the Hyatt Regency, Vancouver, B.C. on Aug. 26 — 28. Write: *Department of Continuing Education, ACOG, One East Wacker Drive, Suite 2700, Chicago, ILL. 60601.*

September

Respiratory Week — 1976 Educational Forum, at the Calgary Inn Hotel, Calgary, Alberta, Sept. 1 - 3, 1976. Contact: *Ms. E. Lord, Registration Chairman, 6528 — 23 Ave. N.E., Calgary, Alberta, T1Y 1V4.*

Ontario Psychogeriatric Association: Third Annual Meeting, to be held at the Talisman Motor Inn, Ottawa, Sept. 20 - 22, 1976. Information from: *Dr. M. Farquhar, P.O. Box 14, Station "C", Toronto, Ontario, M6J 3M7.*

RNAO — 20th Annual Conference at Honey Harbour, Georgian Bay, Ontario. Four unique programs: Sept. 20 - 24, 1976, You as a Person; You as a Team Leader; You as a Manager of Change. Sept. 18 - 25, 1976, Advanced Program in Group Leadership. Contact: *Professional Development Department, RNAO, 33 Price St., Toronto, Ontario, M4W 1Z2.*

Canadian Society of Perfusionists — Annual Dialysis Symposium, to be held at the Chateau Halifax, Nova Scotia, Sept. 25 - 26, 1976. For information, write: *C.S.P., Dialysis Unit, Victoria General Hospital, Halifax, N.S. B3H 2Y9.*

Association of Registered Nurses of Newfoundland — 22nd Annual Meeting to be held at the Holiday Inn, St. John's, Sept. 27 - 29, 1976. For further information, write: *ARNN, 67 LeMarchant Road, St. John's, Newfoundland.*

The Nurses Association of the American College of Obstetricians and Gynecologists (NAACOG) — 3-Day Education Conference to provide obstetrical, gynecological and neonatal nurses with the latest developments in their specialties. To be held in Winnipeg, Manitoba, Sept. 30 - Oct. 2, 1976. Contact: *Karen Flatley, R.N., Administrator, NAACOG, One East Wacker Drive, Suite 2700, Chicago, Illinois. 60601.*

October

Association of Canadian Medical Colleges — Annual Meeting to be held at the Bayshore Inn, Vancouver, B.C., Oct. 3 - 5, 1976. The Association of University Schools of Nursing, and of Rehabilitation, are two associations holding meetings in conjunction with ACMC. Information: *Mr. C.A. Casterton, Executive Secretary, Association of Canadian Medical Colleges, 151 Slater Street, Ottawa, Canada, K1P 5H3.*

Symposium on Neurological and Neurosurgical Nursing, Toronto, Ontario. Oct. 14 - 16, 1976. For further information contact: *Nursing Department, The Toronto Western Hospital, 399 Bathurst St., Toronto, Ontario. M5T 2S8.*

Practical Rehabilitation Techniques at the Calgary General Hospital offered by the Department of Physical Medicine and Rehabilitation and the Department of Nursing Service, Oct. 18 - 22, 1976. Information from: *Director of Nursing, Physical Medicine and Rehabilitation, Calgary General Hospital, 841 Centre Avenue East, Calgary, Alta., T2E 0A1.*

Effective Diabetes Education — A Workshop, to be held at Village Green Inn, Vernon, B.C., October 22 — 23, 1976. For further information contact: *Mrs. Bernice Strachan, R.N., Diabetes Day Centre, Vernon Jubilee Hospital, Vernon, B.C.*

Annual Conference of Ontario Occupational Health Nurses Association to be held at the Park Hotel, Niagara Falls, Ontario, Oct. 26 - 29, 1976. Information from: *Anna L. O'Brien, Publicity Chairman, OCHNA, 320 Queenston Rd., St. Catharines, Ontario.*

Order of Nurses of Quebec — Annual General Meeting, to be held at the Queen Elizabeth Hotel, Montreal, October 27 - 29, 1976. For information, contact: *ONQ, 4200 Dorchester Blvd., Montreal, Quebec, H3A 1V2.*

The Professional Team Approach to Cancer Health Care, to be held in San Francisco, California, for all medical and professional personnel involved in the care of cancer patients October 30, 1976. For information write: *Department of Continuing Education, Mount Zion Hospital and Medical Center, P.O. Box 7921, San Francisco, California 94120.*

November

An Examination of the State of the Art of Palliative Care of Terminal Patients and their Families, to be held in Montreal, Nov. 3 - 5, 1976. Guest speakers include: Dr. Cecily Saunders and Dr. Elizabeth Kübler-Ross. For further information write: *The Post-Graduate Board, Royal Victoria Hospital, 687 Pine Avenue West, Montreal, Quebec. H3A 1A1.*

Ontario Public Health Association 27th Annual Meeting to be held at the Skyline Hotel, Toronto on Nov. 3 - 5 1976. Information from: *Kae Sutherland, OPHA, 7 Carlis Place, Port Credit, Ontario, L5G 1A8.*

Second Northeast Canadian/American Health Conference to be held at the Sheraton-Boston Hotel, Boston, Mass. on Nov. 3 - 6, 1976. Information from: *Dr. R. Robillard, Fédération des médecins spécialistes du Québec, Suite 601, 625 Avenue du Président Kennedy, Montréal, Québec H3A 1K2.*

Canadian Association on Gerontology educational meeting to be held at Hotel Vancouver, Vancouver, B.C. on Nov. 11 - 13, 1976. Information from: *CAG - 76, 2210 W. 12th Avenue, Vancouver, B.C., V6K 2N6.*

Although described as an indicator of right heart function, Central Venous Pressure helps to determine the overall cardiovascular status of the patient. The nurse who understands the underlying principles can adapt this procedure to the individual needs of each patient.

Monitoring CENTRAL VENOUS PRESSURE: principles, procedures and problems

Gloria Kay and Patricia Kearns

CENTRAL VENOUS PRESSURE (CVP) is the hydrostatic pressure in the large veins close to the heart, at the level of the right atrium that provides the force necessary to fill the right side of the heart during diastole. "Central veins" refer to the intrathoracic portions of the superior and inferior vena cava. CVP is measured as the number of centimeters of water that can be raised by the pressure within the central veins. The reference point for measurement is taken to be the middle of the right atrium, located four to five centimeters below the sternal angle (the relatively prominent ridge where the second rib articulates with the sternum).

Nurses are frequently required to monitor central venous pressure when caring for acutely ill patients. This pressure is an adjunctive vital sign, providing information about the patient's clinical status. Although CVP may be precisely described as an indicator of right heart function, it is generally perceived as a useful indicator of overall cardiovascular status. Hence it is used as a guide for intravenous (IV) fluid management of patients in shock; with dehydration; postoperatively; and those in whom cardiac decompensation might be anticipated (i.e. patients with a history of cardiac dysfunction who require IV fluids). The central venous line may also be used for medication administration, in hyperalimentation, and, occasionally, for the insertion of a pacing electrode.

Physiological factors

The CVP level of each patient is influenced by a number of interdependent physiological factors. For clarity, these factors are discussed separately, but it is important to remember that changes in any one factor may be concurrently or serially reflected among the others (See figure 1). These factors include:

— intravascular volume and flow,
— contractility of the heart chambers,
— neural regulation of the venous system, and
— intrathoracic pressure.

Intravascular volume and flow: The volume and flow of blood being returned to the heart from peripheral vessels varies with changes in intravascular volume. A decreased volume reduces the pressure in the central veins; an increased amount raises this pressure.

Reductions in intravascular volume may result from absolute loss or from alterations in distribution. Examples of absolute volume loss are blood loss due to hemorrhage, plasma loss from burns, or fluid loss in vomiting and diarrhea. Volume reduction due to alterations in distribution occurs when increased capillary permeability redistributes fluid from the caillaries to the interstitial spaces, as happens during intestinal obstruction.[1]

Increases in intravascular volume may be caused by fluid retention, as in hyperaldosteronism; or by overloading the system, due to excessive fluid replacement.

Contractility and distensibility of the heart: The volume and pressure in the central veins depend on the efficiency with which the right heart chambers relax to receive, and contract to forward, the blood being returned to them. Right ventricular failure may have a primary cause, or be secondary to left ventricular failure. A failing right ventricle will not empty normally and blood will accumulate, causing an increase in CVP.

Neural regulation of the venous system: Neural regulation of the central veins is influenced by the sympathetic nervous system. Sympathetic nerve endings release the hormone norepinephrine, which stimulates alpha and beta nerve receptors. Alpha receptors are distributed throughout the arterial and venous systems, whereas beta receptors are predominantly arterial. Alpha receptor stimulation results in vasoconstriction, while beta receptors respond with vasodilatation. Therefore, events causing sympathetic nervous system stimulation, such as physical exercise or emotional stress, result in vasoconstriction and increased venous tone, potentiating increased venous return to the right heart and an increased CVP.

Intrathoracic pressure: Pressure within the central veins is influenced by changes in intrathoracic pressure, particularly fluctuations occasioned by respiration. During inspiration, intrathoracic pressure is lowered with a concomitant lowering of CVP. On expiration, intrathoracic pressure rises, leading to a rise in CVP. Sharply increased pressure readings occur with coughing or the Valsalva maneuver.*

▷

* *Valsalva Maneuver: increase of intrapulmonic pressure by forcible exhalation against the closed glottis.*

CVP

Monitoring

Figure 1 **Physiological Factors Affecting Central Venous Pressure**

Factors resulting in decreased CVP		Factors resulting in increased CVP	
Blood or plasma loss Diuretics	↓ volume	Increased IV fluids Fluid retention	↑ volume
		Congestive heart failure	↓ cardiac efficiency
Heat	↓ venous tone (vasodilatation)	Exercise	↑ venous tone
Inspiration	↓ intrathoracic pressure (more negative)	Expiration	↑ intrathoracic pressure (less negative)

Preparation for monitoring

A small-bore, plastic, vascular catheter is introduced into a peripheral vein percutaneously or by direct intravenous cutdown. Frequent sites are the external jugular, subclavian, femoral, cephalic, and basilic veins.

It is preferable that the patient receive an explanation of the procedure before the necessary equipment is brought to the bedside.

The type of equipment and specific manner of measurement vary somewhat among hospitals, but nurses who understand the basic principles and method can readily adapt or improvise.(See figure 2).

Assembling the equipment at the bedside affords an opportunity to review again with the patient what is happening and respond to further questions. The IV infusion tubing and the CVP apparatus are prepared by attaching one outlet of the four-way stopcock to the tubing leading to the IV solution bottle, attaching the second outlet to the extension leading to the water manometer, and joining the third outlet to the tubing leading to the patient's vein. Figure three is a schematic diagram of the set-up, and indicates how the direction and flow of the IV solution is altered by changing the stopcock.

The skin area surrounding the insertion site is prepared by shaving, if necessary, applying a tourniquet or blood pressure cuff, and surgically cleansing the patient's skin. Wearing sterile gloves, the doctor inserts the intracatheter, sutures it in place, attaches it to the CVP line, and flushes the line to ensure patency.

Antibiotic spray is applied to the skin around the site of insertion, a sterile dressing is applied, and taped to stabilize the catheter. The adhesive tape or Elastoplast** is labeled with the time and date of insertion. This date is important, since hospital policy dictates the frequency of site and catheter changes. A chest X ray is performed at this time to verify the precise location of the intracatheter.

In preparation for monitoring CVP, a "zero level" must be established. The zero indicator on the water manometer should be level with the patient's right atrium (see illustration). To establish the zero:

- Have the patient lie flat in bed, if the recumbent position can be tolerated.
- Abduct the arm.
- Using the midclavicle as a guide, locate the fourth intercostal space.
- Follow this space across the patient's chest to the midaxillary line (approximately 5 centimeters down from the top of the chest). This point approximates the position of the right atrium.
- Mark the patient's skin with an "X" and use this point as zero for all future CVP readings.
- Using a carpenter's level, or comparable device, measure a direct baseline from the midaxillary "X" to zero on the manometer, stabilizing the manometer's zero at this level.
- Using this procedure, normal CVP is 4 to 12 centimeters of water.

Monitoring

CVP readings are usually monitored and recorded hourly. Serial pressure monitoring provides more useful information than a single reading.

- Before every reading, establish the patient in the identified position, confirm the zero point, and determine catheter patency by increasing the IV infusion briefly to permit a rapid flow rate.
- Turning the stopcock, allow the IV solution to run into the water manometer to a level 10 to 20 centimeters above the expected pressure reading. Avoid fluid overflow of the manometer, to decrease sources of contamination and/or infection.
- Close off the flow from the IV solution.
- Turn the stopcock to allow fluid in the manometer to flow into the catheter. The manometer fluid falls rapidly and fluctuates slightly with the patient's respirations.
- Observe the pulsation in the manometer as the fluid drops . When the level is constant except for respiratory fluctuations, record the CVP level using the maximum reading.
- Return the stopcock to the IV infusion position and re-establish the flow from the solution bottle into the patient's vein. A microdrip is useful in regulating IV flow.

** *Elastoplast is a registered trademark of Smith and Nephew Ltd., Lachine, Québec.*

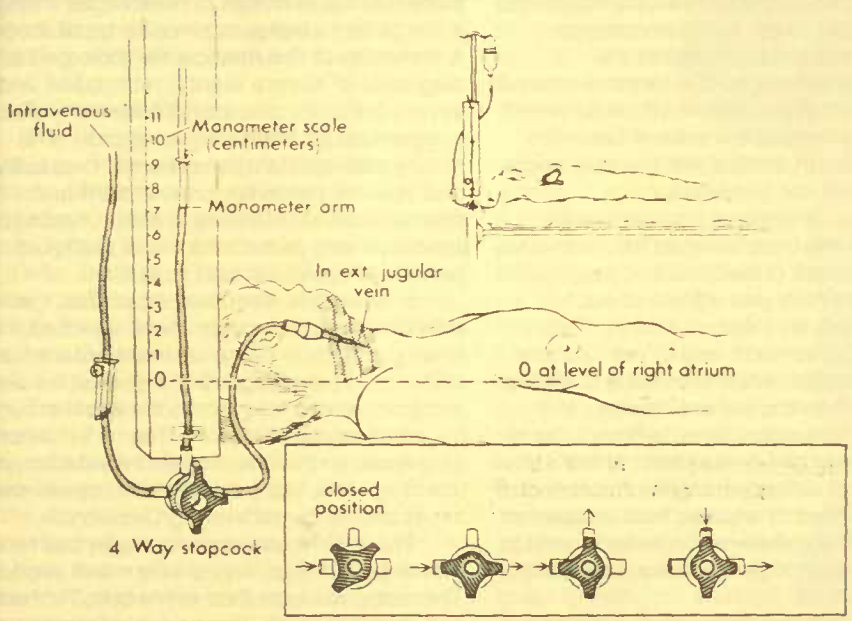
Figure 2

CVP Equipment Includes:

1. Tray for skin preparation, with razor and antiseptic solution.
2. Tourniquet or blood pressure cuff.
3. IV cutdown tray, including sutures.
4. Intracatheters (size depends on vein to be used).
5. IV tubing and pole.
6. Water manometer.
7. Four-way stopcock.
8. IV fluid, as ordered by physician.
9. Sterile dry dressing may be included on cutdown tray.
10. Antibiotic spray.
11. Adhesive tape (usually 3" Elastoplast).
12. Sterile gloves for doctor.
13. Armboard, if required.
14. Carpenter's level or other device for establishing the zero point.
15. Heparin 500 - 1000 units/L, if ordered by doctor.

Figure 3*

Central Venous Pressure Via Jugular Vein



Precautions

An awareness of possible problems will assist nurses to anticipate, prevent, or alleviate difficulties inherent in caring for patients with CVP lines. Problems to watch for:

Interference in transmission of pressure: Obstructions to free flow within the system may be caused by kinks or plugging in catheter or tubing. Excessive tubing should be loosely coiled. The use of an armboard can prevent kinking due to joint flexion and other patient movements.

Clotting of blood within the catheter may be prevented by periodic flushing of the line, and by the addition of heparin to the IV solution. The small quantity of heparin commonly used does not adversely affect the body's clotting mechanism.

If flow becomes sluggish or blocked, do not force fluid through the intracatheter by squeezing the pump chamber. Notify the physician.

Infection: The observance of aseptic technique during catheter insertion and during application of dressings aids in preventing infection. The frequency with which the dressing is changed varies with the hospital and doctor concerned. Although this technique is not always delegated to the nurse (certain doctors prefer to do it themselves), her main responsibility is in observing for complications. Phlebitis is a hazard that may be eased with warm compresses or may necessitate a change of catheter site. If it becomes necessary to change the catheter site, the tip of the catheter should be sent for culture and sensitivity in a sterile container.

Catheter breakage: At the time of insertion, care should be exercised to prevent catheter damage by the needle point. If the catheter breaks while in the vein, apply pressure over the vein and call the physician immediately. Upon removal, the catheter should be examined to ensure that it is intact.

Summary

When caring for patients with CVP lines, nursing assessments are aided by knowledge of the interdependence of physiological factors such as cardiovascular volume and flow, cardiac efficiency and central vein capacity. Comprehension of the underlying principles facilitates adaptation of the procedure to patient needs and to the available resources.

References

1 Guyton, Arthur Clifton. *Basic human physiology: Normal function and mechanism of disease.* Toronto, Saunders, 1971. p. 240-1.

Gloria Kay, R.N., B.Sc.N., B.A., M.Sc.N., is coordinator of research (nursing) at the Sunnybrook Medical Centre, Toronto. Patiricia Kearns, R.N., B.N., M.Sc.N., is clinical nurse specialist in cardiology at the same center.

* Reprinted with permission from: *Concepts and Practices of intensive care for nurse specialists.* Edited by L.E. Meltzer, F.G. Abdellah and J.R. Kitchell, Bowie, Md., Charles Press Inc. 1969. p. 294.

Coping with the aggressiv



Extremely aggressive patients in mental institutions constitute a threat to staff and other patients that usually necessitates the use of physical restraints. With chronically aggressive patients this cycle of behaviors is defeating for both the staff and the patient. In this case history the authors describe how positive and negative reinforcement and shaping were used to alter the previously unmanageable aggression of a 36-year-old male psychiatric patient.

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Wayne Matheson, Maqbul Mian, Joyce MacLeod

The most anxiety-provoking behaviors of patients in mental institutions are those where threat of assault is always present and actual assault upon staff is a distinct possibility. The usual result of such behavior is that the offending patient is both physically restrained and verbally rebuked. Another common consequence is deprivation and the withholding of privileges. Continuous assault upon staff or other patients results in a cycle of punishment whereby the patient becomes isolated and out of contact with the daily social environment of the institution.

Recently, behavioral approaches to aggression have been used as an alternative to the punitive use of isolation and deprivation (the problems with side-effects of such punishment are well-documented[1]). This involves the systematic use of positive and negative reinforcement and shaping to change behavior.[2] When the patient displays the appropriate, non-aggressive behavior, he is positively reinforced (rewarded); at the same time, negative reinforcement (reinforcement of attempts to avoid or escape from discomfort resulting from aggressive behavior) is used to encourage appropriate behavior instead of aggression.

One of the difficulties with this method is that the alternative behavior must first be occasioned. Somehow a replacement behavior must be made to appear. It is possible that a replacement behavior does not exist and must be taught. On the other hand, if the treatment staff are satisfied that an alternative behavior does exist, even at a low level of probability, they can *prompt* for its appearance. With assaultive behavior, the replacement behavior need not be complicated or complex enough to require teaching. Indeed it may be sufficient that the individual do "nothing" rather than assault. In other words, the patient need just stop the old behavior rather than produce a novel response. In that case the staff could positively reinforce the behavior of "not fighting."

In the following case history, the staff decided to try the use of behavioral methods to gain control over a patient who had not responded to the punishment techniques of isolation, deprivation and physical restraints.

Case History

The patient chosen was a 36-year-old, single, obese male who had been in the hospital since 1955. Previous therapeutic efforts had been inconclusive and, in fact, there was no evidence of meaningful change in the patient's behavior since early childhood. A summary of the medical file indicated a diagnosis of severe mental retardation and severe behavior disorder. There were also suggestions of brain trauma at birth. The history was replete with accounts of assaultive and abusive behavior, uncontrolled and spontaneous outbursts of violence, feelings of suspicion and persecution, and preferred periods of seclusion and isolation.

Despite this discouraging profile, the individual read the paper daily, watched the news on TV with behavior that bordered on addiction, and willingly discussed, at his own initiation, issues relevant to the world around his small prison-like room. These behaviors cast doubt on the diagnosis of retardation, yet this diagnosis had persisted across several assessments by different professionals.

The patient was kept in a single-bed room with a locked door and a wire mesh window. The room was furnished with a bed, TV, radio, and portable toilet. The portable toilet was necessary since the patient would not use ward toilet facilities because, he claimed, "the other patients are after me." Access to the room was limited to one or two preferred staff with whom the patient had rapport. When the patient was allowed to roam free, he assaulted staff or other patients almost immediately. On occasion, he even attacked staff in his own room. The patient was allowed to leave his room only to bathe, and this ritual resulted in a constant physical struggle with accompanying staff.

The patient was extremely fond of his TV privilege, his radio and his daily newspaper.

patient: an alternative punishment



These had been provided without obligation for a number of years despite his constant aggression and threats. Indeed, control over the assaultive behavior seemed to be in the hands of the patient. The staff were determined in the first stage to alter this control and to do so without the previous struggling, wrestling, and consequent use of punishment.

Treatment plan

The first step was to try to gain some control over the patient's reinforcement system. Since he was extremely fond of his TV, radio, and daily newspaper — and the staff could control these sources of reinforcement — it was decided to start the program around these variables. A fuse was connected just outside the patient's door which enabled staff to control the power to the TV and radio, and to communicate this to the patient.

The target behavior was the bathing situation. The patient would not presently request a bath even when it was necessary to keep clean. When the staff did require him to bathe, he would fight and struggle with accompanying staff on the way to the bath, in the bath, and on the return trip. As a first step, it was decided that the staff would request that the patient have his bath. If he declined, as expected, the staff would remove the new fuse from the TV and radio, and tell the patient that it would be restored *as soon as* he requested a bath. This is the principle of *negative reinforcement*. Reinforcement is arranged if the person avoids, or escapes, from his deprivation or discomfort. Whenever the patient requested assistance or indicated he was ready to cooperate, he was to be assisted *immediately* and the fuse was also replaced *immediately*. This procedure was repeated until a pattern was established and the patient frequently requested his bath even though he later fought.

In the second phase, if the patient aggressed on the trip to the bath, he was taken back to his room and the fuse was again removed. He was told that it would be returned if he asked for his bath and then went to the bath without a struggle. In this way the staff attempted to *shape* non-aggressive behavior.

During the trip to the bath any non-aggressive behavior was praised, encouraged and given appreciation, and special visits to his room were arranged for such cooperation. This was the application of the principle of *positive reinforcement*.

Gradually, it became clear that the patient was now asking for his bath, going to the bath without a struggle, taking his bath and then fighting and wrestling on the return trip. At this point, the staff returned the patient to his room after the bath and replaced the fuse, because he had produced the target behaviors of requesting a bath and going without a struggle. The daily newspaper, however, was withheld and the patient was reminded that he would have his newspaper each day if he didn't struggle on the way *back* from the bath.

Slowly, over a period of several weeks, the use of positive reinforcement for non-aggressive behavior, negative reinforcement for cooperation and requests for assistance, and shaping of an appropriate chain of behavior enabled the staff to control this patient's aggression. The target behaviors have been met, and now he requests and takes his bath without a struggle. In addition, the staff have extended the behavioral demands for cooperation to include his weekly injection of medication. This, too, was a ritual that necessitated a wrestling match. The same positive reinforcement-negative reinforcement paradigm was instituted with the fuse system and the patient now assists staff with his medication.

Conclusion

In the past, staff had considered this patient an unrepentant and incorrigible demon. Gradually, as cooperative behavior appeared, they had second thoughts and began to see some humanity peeking through. For the first time in the memory of most of them, this patient has been taking his baths and medications without a struggle. He is also less verbally abusive to staff.

The attitude towards this patient has changed from extreme pessimism and despair, to a more optimistic, positive approach. There is hope that the program can be extended to include toilet behavior and that gradually the patient will be moved into ward socialization with others.

This example illustrates how effective the use of reinforcement can be in patient management. The application of a non-punitive approach is being promoted more and more in all areas of behavior management. Hopefully, the helping persons who are involved with individuals whose behavior evokes anger and retaliation in others, can control their own reactions sufficiently to appreciate that change is more likely through use of a reinforcement model than a punishment model.

References

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2 Matheson, W.E. Functional help, by... and J. Martin. Sydney, Cape Breton Hospital, 1976. Unpublished.

The authors are on the staff of Cape Breton Hospital in Sydney River, Nova Scotia. Wayne Matheson (Ph.D., University of Alberta) is Chief Psychologist, Maqbul Mian (M.D., University of Punjab) is Medical Director and Joyce MacLeod (R.N., Glace Bay General Hospital, Glace Bay, N.S.) is Head Nurse in the male psychiatric unit.

After several meetings about the patient, Matheson and Mian drew up the treatment plan described above, and it was implemented by MacLeod and the nursing staff in the unit.

Understanding the Patient in E

Caring for a patient in an emergency department demands much more than technical nursing skills. Quality care requires a nurse's understanding of many factors contributing to the emotional state and behavior of the patient and his relatives in an emergency.

Wendy McKnight

The patient in emergency faces a situation of sometimes overwhelming psychological impact. His emotional state may be a reflection of the event prompting his unexpected admission to the emergency department, of his physical condition, or of the strange environment of the emergency department itself. The reactions of the patient's relatives and friends will also influence how he responds to his suddenly altered circumstances.



The Patient

An elective admission to the hospital gives the patient time to prepare himself for an absence from home and work. The emergency patient has no time to prepare himself practically or psychologically for his admission, no time to develop coping mechanisms. The event bringing him to emergency may represent a sudden and frightening change in his physical state. Other concerns may be related to his job, his financial situation, his family, or his prognosis. These concerns, suddenly magnified, will affect his behavior.

The word 'emergency' has frightening connotations. It suggests an urgent, life-threatening situation. The emergency environment; white, fast-paced, and efficient, may also appear threatening to the patient.

ERGENCY

Consequently, he may automatically react with anxiety and fear although his condition may not be considered urgent or acute by the attending staff.

A patient in emergency may accept care by hospital staff with quiet resignation, but this attitude should not be misunderstood by a nurse, as it often stems from the patient's feeling of loss of control. A feeling of helplessness in an emergency situation begins before the patient's admission to hospital. A person has no control in the event of sudden illness or accident and may submit to treatment with seeming complacency because he feels very helpless. For example, most patients rarely question what is being done to them by ambulance or hospital personnel; instead they quietly accept the care and treatment administered.

The total situation of an emergency admission imposes severe psychological stress on the patient and as a result he may not understand everything being explained to him. A nurse may help him to understand by simple explanations of procedures and equipment, and frequent repetition of such explanations.

Fear and anxiety are predominant emotions in the emergency patient. Anxiety has been defined by Robinson as a persistent uneasiness due to internal stimuli. Fear is elicited by external stimuli. An individual usually knows what causes his fear but is often unable to identify the sources of his anxiety. Consequently, it is easier for health personnel to attempt to reduce or alleviate fear than to cope with anxiety. If the patient can be helped to identify the cause of his anxiety, then appropriate steps can be taken to alleviate it. If the source of anxiety cannot be determined, however, it is questionable whether the patient will be successfully reassured. Nevertheless, nursing support ought to be given in the form of explanations, touch and overt evidence of caring.

Many patients in emergency experience some degree of pain. Pain is an intensely personal and all-encompassing phenomenon. It is impossible for one person to enter into the experience of another's pain. It intensifies fear and anxiety, and these emotions may increase pain. Unless analgesics are contraindicated by the patient's condition, the most important and considerate nursing measure in the treatment of pain is the swift administration of an analgesic as ordered by the doctor. Emotional support of the patient is important to reduce the level of fear and anxiety related to pain.

Such support is especially important when uncomfortable procedures are being carried out. For example, the insertion of a chest tube is often frightening to a patient. This treatment should be fully explained before and during the procedure. A nurse should take time to listen to the patient's concerns, and to remain close to the patient during the treatment to give emotional and physical support while assisting the doctor. Two-way communication is reassuring to a patient and may help to alleviate fear and discomfort.

The health team involved should be alert to all behavioral cues which will help to identify the concerns and needs of the patient. All behavior has meaning. Facial expression, tone of voice and posture are some forms of nonverbal communication. Such behaviors are cues, which, when correctly interpreted, can assist health personnel in deciding whether or not the patient is comfortably coping with the situation and responding to treatment.

It is important for a nurse to verify with the patient her perceptions of his behavior (the meaning she gives to his action). Through verification, a more accurate assessment of the meaning behind the patient's behavior can be made and the nurse can then take appropriate action.

Individuals tend to interpret the behavior of others according to their personal orientation, including past experiences, culture, age and sex. These interpretations may be incorrect because our perceptions are highly personalized and therefore sometimes incongruous. The care resulting from our personal interpretations of behavior may be inappropriate.

For example, a patient is lying on a stretcher in emergency; his condition is stable and he is waiting to be transferred to a ward. A nurse notices his hand grip tighten on the side rail. Her interpretation of this behavior may be that the patient is concerned about his prognosis and his admission to hospital. The nurse says "Don't worry. Everything will be all right." She is reassuring the patient according to her own preconceptions and personal interpretation of his behavior. If the nurse had said "I noticed your hand tighten. Is something bothering you?" the patient may have answered "I've just remembered that there was $100.00 in the glove compartment of my car." Here the action taken by the nurse to relieve the source of his concern goes beyond that of a stereotyped response.

It is often difficult to tell whether or not effective psychological support has been given to the patient. Minimal but significant changes in the patient may be seen in such behavioral cues as a more relaxed facial expression or a decreased pulse rate.

"Everything will be all right," is an empty phrase when it stands alone. It acts as a panacea, preventing health personnel from becoming involved with patients. It is used to compensate for lack of time, or for hesitancy due to feelings of discomfort or incompetence when confronted by a patient's emotions and anxieties. It may communicate an uncaring attitude.

Similarly, it is impossible to alleviate anxiety by saying "Don't worry." Such a remark has no value. Unless a nurse knows exactly what is worrying the patient, she cannot know what will alleviate his specific concern. The patient may interpret such a response as a rejection of any expression of a problem or question and therefore the nurse should attempt to find the source of the anxiety.

Relatives and Friends

The emergency situation may also have a strong impact on the relatives and friends of the patient. Often they feel very helpless and apprehensive. While the patient is receiving treatment, relatives may wait anxiously in the emergency waiting room. They require the nurse's attention and may be supported by simple, concise, and personal explanations of the patient's condition and care. The quiet relatives who wait patiently need as much attention as those relatives who continually demand reports.

Once the initial care has been given and the patient's condition is stable, visitors may be brought to the bedside. It is often encouraging to the patient to have relatives with him. Visitors may benefit from closeness to the patient and from seeing for themselves what is going on. Hysterical relatives will be of questionable benefit to the patient. Health ▷

personnel should assess each situation individually according to the amount of support relatives will be able to give the patient.

The patient's appearance (for example, if he has sustained a facial injury in a car accident), his general condition, and the reason for unfamiliar equipment should be explained to relatives before they visit. Health personnel too often take for granted that equipment familiar to them is also familiar to the public. A simple intravenous may be very alarming to uninitiated relatives. Relatives and patients often hesitate to question the staff because they appear busy. Health personnel should take the initiative to encourage questions.

The patient's condition may be both unnerving and anxiety-provoking to his relatives. They may feel very uncomfortable if left alone with the patient, because of his illness and the possibility of change in his physical condition. If the patient's condition is such that he can be left alone with his visitors, they should be asked whether or not they would like the nurse to stay.

An accurate interpretaton of the verbal and nonverbal cues expressed by relatives is no less important to the nurse than her perception of the patient's behavioral cues. Relatives should be included as an integral part of the total care of the patient. If the relatives are neglected, then an essential part of the patient's care has been overlooked.

The Emergency Nurse

A nurse's behavior conveys meaning to both patient and relatives. Facial expression, clinical dexterity, and tone of voice are only a few cues open to interpretation by others. A nurse should be constantly aware of how her own behavior is perceived by patients and relatives. If patients or relatives never approach or question a specific nurse, perhaps it is because her behavior is conveying to them that she is either too busy or not sufficiently interested to talk to them.

The behavior of a nurse may be a reflection of certain attitudes, and each nurse ought to be aware of her attitudes and how they affect her care of patients. The individual prejudices of a nurse against alcohol abuse, for example, may predispose her to neglect the emotional support of many emergency patients. A nurse working in a critical care area must also be able to support dying patients and their relatives. If she finds the subject of death personally threatening, she may avoid a very important aspect of patient care. Continual self-evaluation of attitudes and reflected behavior is necessary.

Summary

Psychological care should be integrated with physical care even when one works in a busy 'acute care' environment, be it an emergency department, an intensive care unit, or at the roadside as a member of the ambulance team. The quality of care is enhanced by awareness of psychological needs.

Initially a conscious effort is needed to remember to have cues verified and to be open to noting subtle changes in behavior. If a continuous effort is made by each health team member, this verification process will become automatic without being time-consuming.

All members of the health team must be aware that they are individuals with a multiplicity of factors affecting their thinking, feeling and behavior. They care for individuals who are also unique. A form of support proving successful with one patient may not be effective with another. Each patient must be assessed as an individual before appropriate psychological care can be effectively given. By being open to cues given by the patient and his relatives, and by having perceptions of these cues verified, an important step is taken in deciding on appropriate psychological care.

With an increased awareness of the total psychological impact of the 'emergency' situation on the patient, his relatives — in fact, on the entire health team — individualized patient care will be administered in a more thorough and understanding way.

★ Case Study

It was 10 p.m. one Sunday evening in February. A chaotic day in the Emergency Department of a large general hospital was drawing to a close and the pace was somewhat subdued.

I was tidying up the Emergency Resuscitation Room. The last patient had recently been transferred to a ward. My attention was suddenly drawn to the door as the orderly brought in a gentleman, slumped over in a wheelchair. The patient was obviously fatigued and in considerable distress. I introduced myself to him. As he raised his head I recognized him as Mr. J., a 47-year-old patient we had treated a year before for a severe myocardial infarction.

The patient repeated my name once and then let his head fall again. I noticed that his color was grayish, his skin cold, clammy and diaphoretic. He appeared to be in cardiac difficulty. Mr. J. was helped onto the stretcher, and dressed in a gown. While the orderly went to get the doctor, the patient was given oxygen by mask. Cardiac monitoring was established, his vital signs were taken and an IV of 5 percent D/W was started.

Mr. J. complained of severe chest pain radiating down both arms. His arms were tender and he withdrew them immediately when they were touched.

To relieve his chest pain, the doctor gave IV morphine in small doses ranging from 2 - 5 mgms over a 1-hour period. A total of 20 mgms was administered, before his pain was somewhat eased.

Once treatment had been initiated, I went to the waiting room to talk to his wife, who had brought him to the hospital. She was sitting alone, quietly, smoking a cigarette. No one had yet spoken to her. I sat down beside her and said that her husband was a very sick man, but that his condition was stabilizing and his chest pain was easing. I also told her what was being done for him. I asked her if she would like to visit him, as it seemed to me she would not be likely to ask to see him. She appeared most grateful.

Mr. and Mrs. J. said nothing to each other, as Mrs. J. entered the room. Mr. J. opened his eyes momentarily to acknowledge his wife's

esence but closed them again, his arms ostrate at his sides. When his wife tried to old his hand, Mr. J. asked her not to touch him ecause of the pain. Mrs. J. remained silently eated at the bedside and I remained in the oom with them.

Approximately one hour after admission o the Emergency Department, Mr. J.'s ondition was relatively stable. The cardiac onitor indicated some new cardiac damage nd I watched it closely for further changes. is V/S were stable at 136/96, pulse 86. xygen therapy was continued. An IV was unning to keep the vein open for possible dministration of medication. Soon, his wife eturned to the waiting room to have a igarette. I stayed with Mr. J., who remained ery still and gave no indication that he wanted o talk, move, or be spoken to. Periodically I iped his face with a damp cloth and checked is vital signs.

Two hours after he was brought to mergency Mr. J. was transferred to CCU. hree weeks later, he was ready to go home. I et Mr. and Mrs. J. as he was being ischarged. They both thanked me for all I'd one for them while he was in Emergency. Mr. . said that my presence with him in mergency "had made the difference etween night and day."

Thinking back to that evening, I tried to ecall exactly what I had done which seemed o mean so much to Mr. and Mrs. J. Besides iving him the necessary physical nursing are, I felt I had done little else but be silently supportive to Mr. J. and considerate of his wife. It was not until they thanked me that I realized the importance of this support and dialogue to both of them.

Another individual in a similar physiological state to that of Mr. J. might have required a great deal of verbal support and reassurance. Mr. J. had given me behavioral cues to guide my approach. He kept his eyes closed, withdrew his arms from touch and did not verbally communicate to anyone, suggesting that a silent approach would be most supportive. Apparently, it was.

Nurses in emergency rarely obtain the kind of feedback that allows them to see how successful their support is. Such feedback reinforces the theory that emotional support in the appropriate form is truly an essential part of our nursing care.

Wendy McKnight (R.N., Ottawa Civic Hospital; B.N., McGill University) currently teaches nursing at Queen's University. After graduation, the author worked in the Emergency Department at the Ottawa Civic Hospital where she developed a strong interest in emergency nursing and belief in the importance of emotional support of emergency patients. She intends to return to McGill this fall for graduate studies, clinically specializing in emergency nursing.

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VIP TREATMENT

Proves This Hospital Really Cares

In Nova Scotia, there's a small but growing number of children who have the comfortable knowledge that, should any one of them need hospital care, they can count on their friends at Western King's to look after them.

Dorothy Grant

For a small child, there's nothing quite so traumatic as suddenly finding himself hospitalized. Most hospitals do everything possible to alleviate the devastating experience of even a temporary separation from home and family. But health professionals will be among the first to admit that it isn't easy to convince a sick, lonely child he is among people whose one concern is to get him better as fast as they can!

Western King's Memorial is a small rural hospital in Berwick County, Nova Scotia but its limited size hasn't stopped it from being highly progressive. One of its most successful and innovative programs is a tour especially designed for primary school children. The results have been so impressive that many medical people and educators in Nova Scotia are anxious to see it become an accepted part of the province's early education program.

It all started about two years ago when a registered nurse on W.K.M.'s staff had an idea. It occurred to her that children visit all kinds of places like newspaper plants, bakeries and fire stations on tours organized by their schools. Hospitals, however, are seldom, if ever, included in these trips. She knew some children's hospitals encourage visits prior to scheduled admissions but in an emergency there is no time for orientation or education. So, she

suggested to Yvonne Nichols, the Director of Nurses at Western King's that the hospital offer tours for children in the area. The Director remembered a story one of her nurses had told her. The woman's little boy had just been discharged from hospital and she'd given him an affectionate hug. To her surprise, he looked sadly into her eyes and said, "If you really love me Mommy, why did you ever put me in that place?"

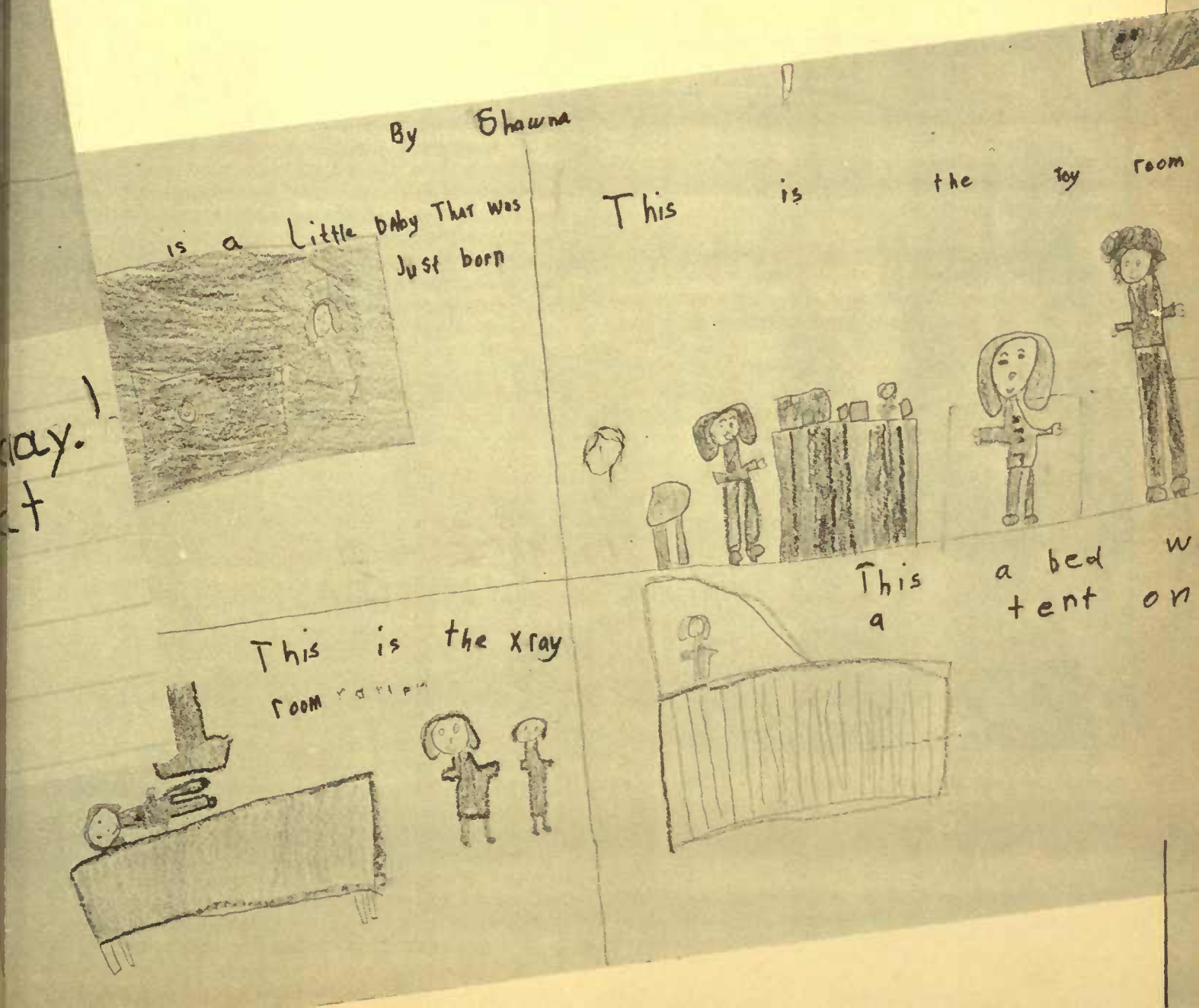
The program got underway in 1974, and, since then, nearly 400 children have visited the hospital where kids get V.I.P. treatment. The Director of Nurses or one of her staff is waiting to greet the children when they arrive and a lot of time is spent finding out what preconceived ideas they have about hospitals. Many children have very serious misconceptions. One little boy's first question was, "Hey, nurse where do you keep all the dead bodies?"

Once the children have run out of questions, they visit the lab where they are introduced to a white-coated technician. The purpose of the room is explained in very simple terms and they're told about the blood tests doctors order for their patients. Children are asked to volunteer to have a finger pricked and invariably, several little girls are the first to comply. (Boys soon follow). The understanding is that volunteers will be the first to see their blood under a microscope. Interestingly enough, not one volunteer, male or female, has ever shed a tear.

Next comes the x-ray department and a simplified explanation of procedures. Each of the children is invited to climb up on the x-ray table to pretend they're having a picture taken. The importance of keeping perfectly still so the technician gets a good x-ray the first time is stressed.

X-ray films of skulls, hands and chests are shown to the children who are invariably impressed by this glimpse of the workings of their bodies.

Hospital laundries, although important, tend to be taken for granted.

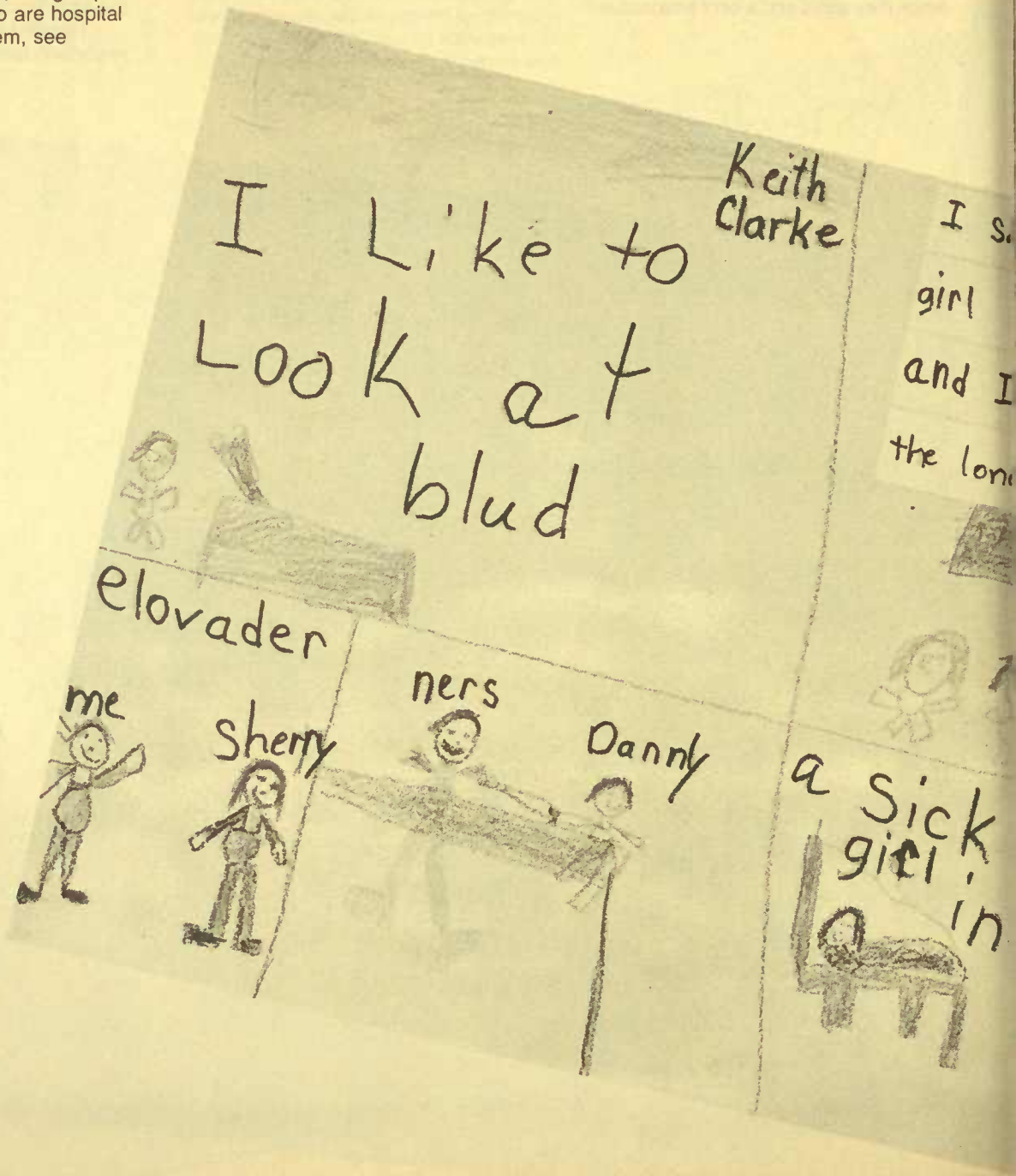


This is not the case at Western King's where the laundry staff look forward to visits of the school children. The children meet each staff member, and are shown the huge machines that churn through tons of dirty hospital linen.

Next comes what is often the highlight of the entire tour. With a little luck, there is a brand new baby in the nursery. Standing on benches, in front of the nursery's glass windows, they watch as a nurse undresses the infant and shows them the umbilical cord. Most children can't wait to get home to tell their parents about what a little baby's "belly button" looks like!

In the pediatric ward, the group meets other children who are hospital patients. They talk to them, see youngsters in croupettes and spend some time in the playroom where convalescing children watch television or play games. Nurses in this department make a point of taking the temperature, pulse, respirations and blood pressure of several children. And a nurse dressed in operating room garb drops by to chat about operations. She explains the reasons why it's necessary to wear masks and gowns and then invites the children to have a short ride on a stretcher. The kids climb on board and groups of six or more giggling boys and girls have a happy ride down a hospital corridor.

At the end of the tour, each child receives a cartoon drawing of a nurse to take home and color. Back at school, the children are asked to illustrate their impressions of the tour. Sometimes, the laundry room is the favorite part of the visit; often it's the new baby, but invariably, the children draw happy, smiling faces. Child psychologists who've seen the drawings have also noted that the children and the hospital personnel are usually pictured as being about the



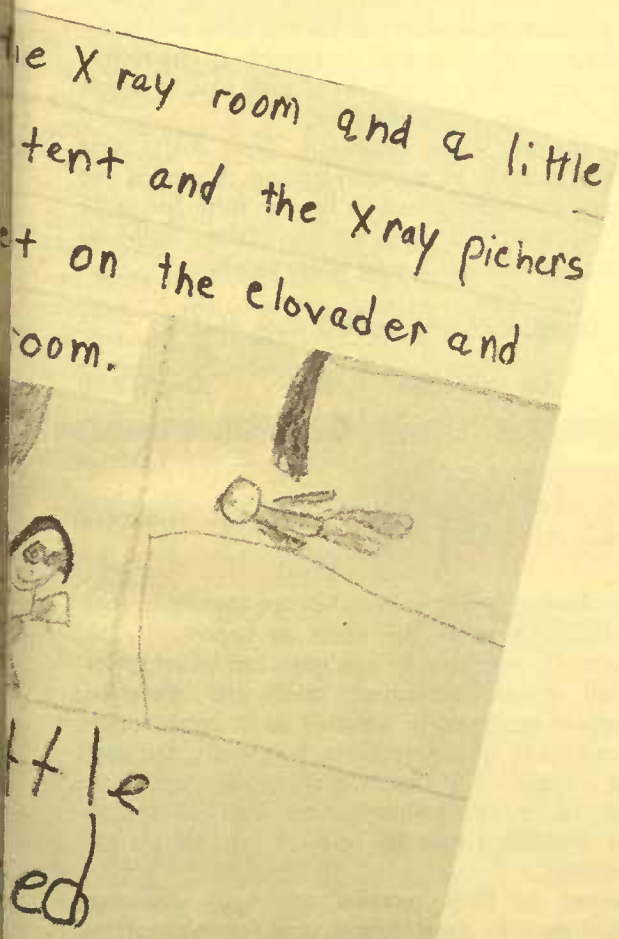
same size or else in the same proportions as in real life. This finding is surprising and significant in the light of the fact that children in hospitals tend to draw themselves as very small figures while doctors and nurses loom large and very ominous. There are other benefits to the hospital tour. Other children in the family are exposed to the enthusiasm of their brothers and sisters and absorb some of the very positive reactions.

Some "graduates" of the tour have since been admitted to Western King's. Has their reaction differed from other youngsters? One mother of a little boy diagnosed as having leukemia told the hospital staff she was amazed at her son's attitude! "I'm quite sure from the way he talked about having to go to the hospital that the tour had a great deal to do with his lack of apprehension about being a patient there." No hospital tour can completely dispel a child's fears but one of the worst things we can do is to ignore their existence in the hope our children never have to be admitted to one.

Western King's Memorial has taken an important step towards convincing children that hospitals really do care and children are tremendously responsive to this knowledge. Ask Yvonne Nichols and she'll tell you about the number of little ones who come to her just before they leave so they can give her a kiss. She and her staff have become the children's friends and the hospital represents an extension of their warmth. It's a good way to begin any relationship

Dorothy Grant is a graduate of Halifax Infirmary school of nursing who has worked as a free-lance writer and broadcaster for the past nine years. She is a frequent contributor to CBC radio and television, for both regional and national networks. Since 1974, she has taken a special interest in consumer-oriented reporting and acts as Nova Scotia representative for the CBC program "Marketplace."

She points out that the children's tour described in this article has inspired plans to implement a similar program at The Izaak Walton Killam Hospital for Children in Halifax.





Digby Mirror Photo

Leader in primary



CLINICAL PROTOCOLS: A Guide for Nurses and Physicians

Designed for *portability* and *quick reference* in the field, this manual of clinical guidelines fits conveniently into the pocket of a lab coat. The protocols themselves are divided between acute problems and chronic diseases. The acute problems are based on the most common presenting complaints seen in the ambulatory adult care setting; and the chronic disease protocols include those conditions most often followed by the nurse practitioner in a continuing care clinic. The authors define an appropriate data base for the common acute problems as well as the chronic illnesses which nurse practitioners may be managing. Presented in a problem-oriented framework, the protocal material outlines both subjective and objective data and includes diagnostic, therapeutic and patient education aspects of the plan. The rationale for each piece of data is presented in the same sequence as the worksheet items.

By Carolyn M. Hudak, *R.N., M.S.; et al.*

Lippincott 461 Pages 1976 $8.75



EMERGENCY–ROOM CARE, 3rd Edition.

A new edition of a favorite textbook brings together the expertise of 29 specialists in all aspects of emergency care. Clear and concise text and accompanying illustrations direct the clinician in the rapid setting of priorities and implementing of treatment with the best and latest techniques. The use of mental checklists and other fast-solution memory devices is discussed, as well as immediate and thorough assessment of incoming cases and coordinated emergency-care response that must often succeed in minutes if it is to succeed at all.

Edited by Charles Eckert, *M.D. By 29 authors.*

Little, Brown 480 Pages Illustrated 1976
Paper, $12.50 Cloth, $17.50

AMBULATORY CARE MANUAL FOR NURSE PRACTITIONERS

Written expressly for the nurse practitioner, this text covers the diagnosis and treatment of commonly seen conditions in adults. The student is taught to interpret signs and symptoms on the basis of history, physical exam, and lab findings; formulate a diagnosis; and treat the patient or (if indicated) refer him to a practitioner with special expertise.

Individual chapters, except for the introductory material, cover conditions of all body systems that are commonly seen in the ambulatory care setting. Discussion of each condition includes history, physical exam findings, lab data, treatment, complications, and follow-up. Each chapter has an extensive section on the pharmacology of medications commonly used in treatment. Throughout, the authors present guidelines for determining boundaries of treatment.

At the end of each chapter is a superb divice for clinical problem-solving, a two-part section entitled Self-Assessment. The first part consists of a series of cases in which the student is asked to analyze the data, and formmulate a diagnosis and a plan of management. The second part consists of detailed discussions of each case to enable the student to test her diagnostis skills.

Most chapters have diagnostic flow charts that give direct assistance in decision-making. Much of the material has been summarized in tabular form for quick reference. The book has about 60 illustrations, half-tone and line. Two-color format is used where helpful.

By Peter T. Capell, *M.D., and* David B. Case, *M.D.*

Lippincott Abt. 400 Pages 1976 Abt. $12.50

DYNAMICS OF PROBLEM ORIENTED APPROACHES

As problem-oriented approaches are applied to their full potential, they offer the nurse an opportunity to: identify patients' problems so that goals can be set, priorities assigned, preventive measures taken, and care given; examine patient problems in isolation or in combination; maintain continuity of observations, judgments, and goals throughout a sequence of time; rapidly retrieve significant data which facilitates communication with other disciplines; and establish a base for research into patient and nursing problems.

Presented in three sections, the book illustrates the potential growth, development, and influence of the problem-oriented process. Discussion of the *concepts* and *theories* related to problem-oriented recording and the problem-oriented approach in the first section is followed and augmented by the section on *implementation.* Aspects of putting a problem-oriented charting system into effect,

health care.

such as preparation, education, implementation, charting and evaluation, are dealt with in each chapter in this section. The third section is concerned with the effect of the problem-oriented approach on future nursing practice.

By Judith Walter, *R.N., M.N.,* Geraldine P. Pardee, *R.N., M.S., and* Doris M. Molbo, *R.N., M.A.*

Lippincott 225 Pages 1976 Abt. $7.50

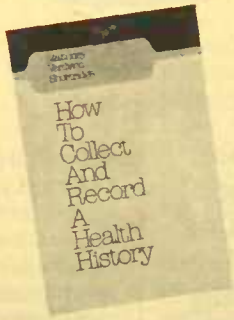


THE PRACTICE OF EMERGENCY NURSING

Practical guidelines in this comprehensive new book will enable the emergency department nurse to properly assess the patient and implement a sound plan of nursing management. *It's the most complete book of its kind!* All types of clinical emergencies are covered, including those associated with particular organ systems and age groups. Emphasized is the emergency nurse's need to acquire and apply facts once associated exclusively with "medical practice." Expanded responsibilities of emergency nursing are stressed, as is the need for teamwork, based on a colleague relationship between physician and nurse.

By James H. Cosgriff, Jr., *M.D., F.A.C.S., and* Diann Laden, *R.N., M.N.; with 31 contributors.*

Lippincott 488 Pages Illustrated 1975 $15.75



HOW TO COLLECT AND RECORD A HEALTH RECORD

This is a unique primary health care book that fits into the POMR methodology by focusing on the health history—the initial component of the POMR data base. The format is unique: it can be used by *all personnel* involved in direct client care; for *all clients* whether well or ill; and at any stage of the client's development. Use of this format establishes base line data, makes the data accessible and retrievable, reduces the need for multiple, repetitive interviews, and affords greater consistency in data collection and recording. This Health History promotes a comprehensive multi-disciplinary approach to health care. Techniques for establishing an environment conducive to effective interviews are discussed along with interviewing procedures. Numerous examples demonstrating effective practitioner-client interaction are included: how to listen to the client; how to help the client verbalize his concerns; how to use directive and non-directive techniques; and how to record the data using the client's words.

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Coming out:
a confrontation with reality



Nursing is a profession that attracts many idealists. In schools of nursing these ideals are reinforced as students learn that good patient care involves meeting the patient's emotional needs as well as his physical needs. Yet, many students come out of training to find that they must compromise their high ideals to stay in line with the realities of hospital economics. In her book, *Reality Shock,* Marlene Kramer describes this period as one of great inner conflict and concludes that the tide of nurses leaving the profession or job-hopping could be abated if students were prepared in school to meet the reality of the working situation. Here, one student describes her reaction to reality shock.

At the time of writing, Jocelyn Harper was a second year nursing student at Algonquin College School of Nursing, Vanier Campus, in Ottawa. She wrote this paper after completing a clinical project at an Ottawa hospital and says that bringing her thoughts and conflicts out in the open helped to stimulate discussion with teachers and other students. The paper was later used to provide food for thought during a faculty-staff development day. The author would like to acknowledge the help and support of her clinical instructor, Linda Stafford.

Jocelyn Harper

"Graduation from a nursing school and induction into employment in a hospital is... a period of great conflict. It is at this time that the professional ideals stressed in school confront the bureaucratic principles that operate in the hospital..."[1] *Marlene Kramer points out that this period of conflict, when the new graduate tries to put her ideals into practice within the structure of hospital administration, is a universal phenomenon. I do not doubt the universality of it. But, while the conflict is universal and the results can be categorized under such headings as hostility, aggression, fatigue and illness, the effects on the individual nurse are intensely personal. Each of us must deal with this inner struggle in our own way.*

My way includes the writing of this article and I have done so for a number of reasons: partly to vent frustrations; partly so that students who feel the same way I do will be able to identify the problem; but mostly in the hope that teachers will realize that reality shock exists and is not just an academic theory and, in light of this realization, make the appropriate curriculum changes to prepare nursing students for reality now.

Theory vs. practice

We all know that what is said in theory and what is really done are not always the same. This happens in any job. In school you learn how it's supposed to be; on the job you learn the way you, or your boss, find it works best. Usually, slight changes are made to ensure that things operate smoothly while still following *most* of the important principles. Such a discrepancy between the *ideal* way of doing things and the *expedient* way is fine when you are dealing with numbers and letters, but there are important differences between nursing and other jobs. For example, when I worked in a bank, on an extremely busy day, most of us had to keep more than $2,000 in our cash drawers even though this was against the rules. The effect on me — I worried occasionally. If I got robbed I would be in trouble, but I didn't feel very guilty about it. Now, take a similar example from nursing. On a busy day, a nurse might have six patients, four of them bedridden. At the end of the day she thinks, "Oh, I should have turned Mr. S. four times, not once, and I know Mrs. K. needed to talk to someone, and I should have taught Mr. H. about such-and-such." She is dealing, not just with money, but with real people. They are sick, they depend on her, and *she knows it.* The feeling you get when you have failed to meet the needs of a person who depends on you is quite different from the feeling you get knowing you have failed to follow some rule concerning money. At the same time, the reality of what you can do on a busy ward, and the ideal you learn in class (what you feel you *should* do) are also quite different.

How do we encounter the reality? What forces in the hospital work towards changing our ideals and habits? They come in all forms. Physicians, other nurses and nurses' aides are usually more than willing to help the new nurse orientate herself to the hospital routine. But this orientation more often than not involves cutting corners in the emotional care of the patient, while stressing technical care and getting through the "work" in the time allotted. The attitudes of head nurses support this; "temps and treatments" are their main concerns. Co-workers can also shape new habits: by simply not responding to suggestions which are too idealistic and school-bookish; by assigning the new nurse to areas where she works fast and efficiently; and by limiting their questions and comments to the basics. After you leave nursing school, you rarely hear about patient care plans anymore.

Suddenly, we find that no one has given us any preparation for the reality of our first job. No one has told us it is physically impossible to do what we were taught and feel is our responsibility to do, and at the same time please our supervisor and keep our job.

When we have to take seven or eight patients each, we have about one hour per patient. In the classroom, we are generally taught as if we have one or two patients and a hospital administration that cares more about patients than about time, organization, and money. Sounds like an ideal situation, a fairy tale. If you expect it to be reality, however, you're in for a shock. Your reaction, if you are like those who have gone before you, will be intense inner conflict. This will probably result in exhaustion until you have solved it. Perhaps you will try to fight for awhile, try to change the ward, attitudes, faulty procedures. However, this is a totally new situation for you. You have had no training in how to deal with it, no anticipatory guidance, and consequently you will probably have no viable ideas about how to deal with it.

Having failed to resolve the conflict this way, you will probably rationalize and join those nurses you couldn't understand before. Or, you may try to keep your ideals and job-hop from one place to another searching for a more ideal setting. As both surveys and common sense will tell you, your job satisfaction will be very low. You can always leave your job, and many do, or you can go back to school for a few years where your ideals will be reinforced. In one study, out of 218 nurses, 116 remained in hospital nursing, 16 went to community health, 15 went to non-nursing jobs, 36 went back to school, 21 quit working because of job dissatisfaction, and 14 turned to raising families.[2]

What can be done to improve the job satisfaction of new nurses? We need more real-life teaching in our schools. As it is now, we are taught the one and only correct way of doing a procedure rather than several practical and correct ways of doing the same procedure. We need to be able to assess priorities and ways to compromise in various situations.

The reality...

In everyday life, you see many examples of instances where basic principles of quality care are not followed, where the needs of the patient are not fully met by the health care providers involved — whether the procedure is asepsis or verbal communication. Think about it. How often have you, as a nurse, observed one or more of the following:

1. An ambulance attendant is not notified by the doctor involved in the case that a patient he has brought in to the hospital has been diagnosed as having a contagious disease. The doctor comments in a facetious manner "could be smallpox."
2. An elderly lady with psychiatric problems is ignored when she complains about having her possessions stolen. The nurses do not attempt to point out her wallet (or whatever) on the dresser but speak rudely to her and tend to ignore her bell.
3. A young patient in traction says he doesn't need a backrub. Most of the nurses on the floor accept his statement at face value. One nurse takes the time to talk to him about the necessity of preventing bedsores and finds, on commencing a backrub, a reddened area near his coccyx.
4. A confused, elderly lady becomes the subject of much hilarity as nurses "try to get a milkshake down her." While she moans and groans, nurses from all over the floor take part in the fun through the intercom system as if she isn't there; even the orderlies join in.

By putting the "realities" of hospital work into focus, I hope to make it harder for all of us new graduates to appease our consciences and rationalize any questionable techniques we use. Next time you see rules being broken or are tempted to do it yourself, for whatever reason, think back and know that you are not alone, and that we are all having the same conflicts.

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SLEEPLESSNESS— CAN YOU HELP?

Sister Loretta Gillis

"If the matter is one that can be settled by observation, make the observation yourself. Aristotle could have avoided the mistake of thinking that women have fewer teeth than men, by the simple device of asking Mrs. Aristotle to keep her mouth opened while he counted. He did not do so because he thought he knew. Thinking you know when in fact you don't is a fatal mistake to which we are all prone."[1]

Automatic vs. deliberative nursing activity

Too often, nurses make hurried and stereotyped assessments about patient behavior on the basis of "past experience." Frequently, the present situation is not fully explored and the meaning of the behavior is, therefore, not understood. Thus, the need expressed by the behavior remains unmet. One patient behavior that nurses deal with constantly regardless of the specific illness category — medical, surgical, psychiatric — is difficulty in sleeping. This universal problem taxes the creativity and expertise of all health workers.

How does the nurse respond to this problem? Does it matter *how* the nurse approaches the patient? Can it be shown specifically that *what* the nurse does for her patient significantly influences the patient's ability to sleep? To help find answers to these questions, a study was conducted to observe the effects of deliberative nursing activities on patients' inability to sleep.

For the purposes of the study, a distinction was made between deliberative and automatic nursing activity. *Deliberative nursing activity* was defined as follows:

1 The nurse observes the patient's appearance and behavior.
2 The nurse ascertains the specific meaning of the patient's behavior by exploring her observations with him.
3 The nurse determines whether or not the patient is in distress.
4 If the patient is in distress, the nurse finds out what activity is needed to relieve it.
5 The nurse carries out this activity to improve the patient's initial behavior and relieve the distress.
6 The nurse evaluates the effect of her activity by observing the patient's verbal and nonverbal behavior.
7 If the patient is not relieved of his distress, the nurse repeats the same process again until the patient is relieved.

Any nursing activity which did not fulfil the above conditions of the deliberative process was defined as *automatic nursing activity.*

The study was conducted on one medical and two surgical units of a small general hospital between the hours of 12:00 a.m. and 4:00 a.m. The sample population included all patients who summoned help by ringing the call light. This activity was regarded as an indication of inability to sleep and a signal for help from the nurse. The patients in the sample population were randomly divided into a control group and an experimental group by alternating the response to the call light. The staff nurse answered the first call light, the investigator the second, and this procedure was continued throughout the hours of the study.

The patients in the control group, a total of ten, were cared for by the staff nurse. The nine alternate patients, made up the experimental group and were cared for by the investigator who used the deliberative process in all cases. In order to determine if there was any relationship between the type of nursing activity and relief from sleeplessness, the following data were examined:

1 observation of the patient when the nurse entered the patient's room after the call light sounded
2 the activity of the nurse in response to the patient's complaints of sleeplessness
3 the results of the activity on the patient.

Records of nurse-patient interactions were kept for both experimental and control patients and the data were analyzed to determine whether a deliberative or automatic nursing process was used. Patients involved in the study were checked at half-hour intervals for one hour following nursing intervention to determine whether or not they were sleeping. One example of an interaction which took place between nurse and patient is indicated in Table 1. This incident illustrates the approach used with patients in the experimental group. Step by step, the nurse observed and verified the patient's needs and was able to respond specifically to these so that the ▷

Table 1

Experimental Group	Name: Mrs. D. Diagnosis: Cholecystectomy

Medication given — None

Observation of the patient when nurse entered room in response to call light being sounded

Patient lying in bed with buzzer still in her hand, looking up at I.V. bottle.

Nurse-Patient Interaction

Patient behavior (verbal and non-verbal)	Nurse said or did
Patient looking up at I.V. bottle, grimacing	"You look like you are worried over the I.V. Is that right?"
"Yes," she said, "I am. You know I was just to the operating room today and they still have these tubes in. I got so frightened when I awoke and saw them."	"Do you mean you are wondering if they are all working alright? Would you like me to check them?"
"Would you please? The last time I had so much trouble because of the catheter. I think it was an infection and I am so worried that it will happen again."	I checked the I.V., Levine tube and catheter. All were working perfectly. I said, "The tubes are all running perfectly; do you feel better about it now?"
"I was very worried but now I can relax since you checked them."	"You do look more relaxed now but you still look warm and uncomfortable. Do you think it might help if I sponged you off and rubbed your back?"
"Could you nurse? I am so scared to move with all these tubes that it's very difficult to get comfortable."	Sponged her off, rubbed her back and made her comfortable in bed. "You look like you are ready to sleep now, but I am wondering if you would like your pain medication before I leave you."
"Oh no, I feel so good now I think I will get right back to sleep. Will you be around if I need something later on?"	"Sure I will, and remember we will watch the tubes while you sleep so you need not worry."
"Thank you nurse. That's a big relief."	

Need of Patient

To have someone check the tubes and tell her they were working alright.

To be positioned comfortably in bed.

Activity of the nurse:

Checked the tubes for proper functioning, told patient they were working properly.

Positioned patient comfortably in bed.

Results of activity immediate:

"I feel so good now. I think I will get right back to sleep."

"That's a big relief."

1/2 hour — Asleep, eyes closed. No response to name called.

1 hour — Still asleep.

* Example of Form Designed by the Investigator for the Collection of Data (Data included on the form is on Experimental and Control Group Patients)

At Last...



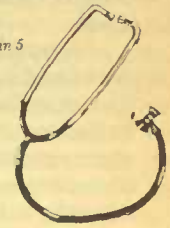
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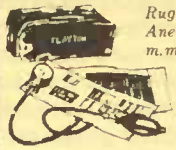
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patient was able to sleep even without the aid of medication. The investigator found that when these specific needs were met only two patients required medication for sleep.

A typical interaction between a staff nurse and a patient in the *control* group is shown in Table 2. *Observation of what transpired in the control group demonstrated that patients' complaints of inability to sleep were considered to be indications for giving medication.*

Results

When the meaning of the patient's inability to sleep was not determined by the nurse, the patient did not experience relief from sleeplessness even when medication was given. All ten patients in the control group received medication. Three of the ten patients were relieved and slept but the other seven patients were still unable to sleep.

In the experimental group where the deliberative process was used to determine the specific meaning of the patient's inability to sleep, seven of the nine patients did not need medication and were able to sleep. The two patients who were given medication did not appear to be helped until other comfort measures were also carried out. One of these two patients, a 13-year-old girl who had had a tonsillectomy, was not relieved of a sore throat by Tylenol, even though both investigator and patient expected that this drug would provide relief. The patient was still restless and uncomfortable until she was given a mouth rinse and helped into a comfortable position. The other patient was a 40-year-old mother of four children who, three days previously had been involved in an accident in which she sustained a fractured hip, fractured vertebrae, multiple bruises and abrasions. She expressed severe pain and was given Pantopon 20 mgm. Relief by medication was not obtained until she was given a sponge bath, made comfortable in bed and given an opportunity to verbalize her feelings about the accident. (She expressed guilt feelings about leaving four small children without a mother for an indefinite period of time).

Records of nurse-patient interaction show that only three patients from the control group and three patients from the experimental group asked directly for medication to help them sleep, but, all ten patients in the control group were given medication. Only two patients in the experimental group were given medication.

Table 2

Control Group

Name: Mrs. F.
Diagnosis: Post-cholecystectomy

Medication given — Demerol 50 mgs

Observation when nurse entered room:
Patient lying in bed, asking for something to help her sleep.

Nurse-Patient interaction

Patient Behavior (verbal and non-verbal)	Nurse said or did
Lying in bed, eyes open, saying, "Can I have something to help me sleep?"	Nurse said, "You know you had your sleeping pill already."
"Yes, but I still can't sleep and the pain is killing me."	"Well, perhaps we can get you something then." Nurse left her, checked chart and got Demerol, 50 mgs ready. Came back and gave it to her saying, "This will help you," then left her.

Need of patient

?

Activity of the nurse:

Gave medication

Results of activity immediate:

Still lying on back — hands clenched as if in pain.

½ hour — Awake — eyes open, responded when name was called.

Conclusion

The results of this study indicate that patients' complaints of inability to sleep are indications of distress which are not necessarily relieved by medication. The complaint needs to be explored by the nurse until sufficient information is obtained to determine the specific response needed to relieve sleeplessness. In this study of 19 patients, it would appear that nurses tend to give medications to relieve patients' inability to sleep even when they do not ask directly for medication.

The study is not meant to question the *value* of medication as a remedy for sleeplessness, provided that the patient's need for medication is validated, and the medication does, in fact, relieve his inability to sleep. When the nurse automatically assumes that the patient needs medication, or when she assumes the patient needs *only* medication, she is not responding to the specific cause of sleeplessness and hence not offering the patient an effective remedy.

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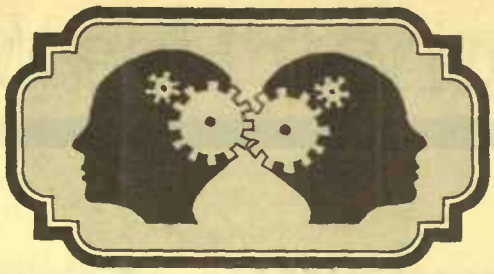
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This article is based on a study done by Sister Loretta Gillis (R.N., St. Joseph's Hospital School of Nursing, Glace Bay, N.S.; B.Sc.N., University of Western Ontario, London; M.Sc., Boston University) entitled The Effect of an Automatic and Deliberative Process of Nursing Activity on Patient's Inability to Sleep. *It was written in partial fulfilment of the requirements for a degree in Master of Science in Nursing. Gillis presently has a joint appointment at St. Francis Xavier University and the Mental Health Centre, both in Antigonish, N.S.*

connection



Is there a nurse in the neighborhood?

Susan N. Steidl

In my ten years as an RN, I have come to realize that nurses, like doctors, have our own form of being "on call" twenty-four hours a day for emergencies. Our patients are usually friends and neighbors. Our emergencies can be anything from a missed birth control pill to a feverish toddler at two o'clock in the morning. The problems we are asked to solve most often are not life-threatening but for the individuals involved they do represent a real crisis.

As professionals, with the special education and expertise of nurses, we have a marvelous opportunity to share our knowledge with others. In our daily contacts with people, there are countless chances to teach correct first aid and home care, to give emotional support in crises, and to interpret doctor's instructions to families. That doesn't mean that our "off duty" hours need to be entirely devoted to these things. Emergencies don't all happen in the same day. Sometimes, though, they do lead to some interesting experiences, like the ones I remember from *my* "off duty" hours in the past few years.

Mary is a seventeen-year-old neighbor who often babysits for us. Her mother called one Sunday morning and asked me to come and see her. She had been having abdominal pain for several hours, but her parents were uncertain what to do about it. When I arrived, I found Mary pale and apprehensive, lying on the sofa. Automatically I checked her pulse while I talked with her. It was strong, but slightly rapid. Her pain was localized in the lower right quadrant. As we talked, the pain became increasingly severe. Trying not to alarm her parents, I suggested that she should be examined by a doctor, but time should not be wasted trying to locate him by phone. The local life squad was there in a few minutes and took her quickly to the hospital, several miles away, where they diagnosed and treated her problem. The final diagnosis was not, as I had suspected, acute appendicitis but a kidney stone and shock that sent Mary to the intensive care unit for two days.

In my "spare time" I have been guilty not only of calling ambulances, but of chasing them as well. Another of my neighbors, George, slipped while mowing a hill. The mower cut through his shoe and severed three toes. I heard the life squad arrive and raced for the scene of the accident. The attendants placed my pale and diaphoretic friend in the ambulance and took off quickly. Remembering my emergency room training, I enlisted the help of my husband (who has some first aid experience) and found the amputated parts in some nearby brush. I made a saline solution of salt, water, and ice, and, in that, we rushed them to the hospital where the doctors were able to use some of them for reconstruction and grafting.

Health education is another important aspect of my "off duty duties". Often, people have the wrong impression of the right thing to do; even those who know what to do are sometimes paralyzed by fear. Once, a mother called me to see her little girl whose fingers had been caught in a car door about an hour before. The skin on two fingers had been broken and the nails appeared to have taken the force of the pressure. They were ecchymotic, with slight bleeding from underneath, and some edema around them. Sally, the child, had been crying from the pain. Her fingers felt very warm and I asked her mother what she had done for her since the accident. She had soaked the fingers in warm Epsom Salts. When the nails discolored she had called a local doctor who told her to release the pressure under the nails by drilling a hole with a hot paper clip. She was afraid and thought I might do this for her. I suggested that first we elevate the hand on pillows and apply ice to reduce the pain and swelling. In the meantime, the mother was able to contact Sally's pediatrician who sent her to the hospital for X-rays to rule out any fractures. By the time we reached the hospital, the edema and pain were much improved and there was no need to pierce the nail.

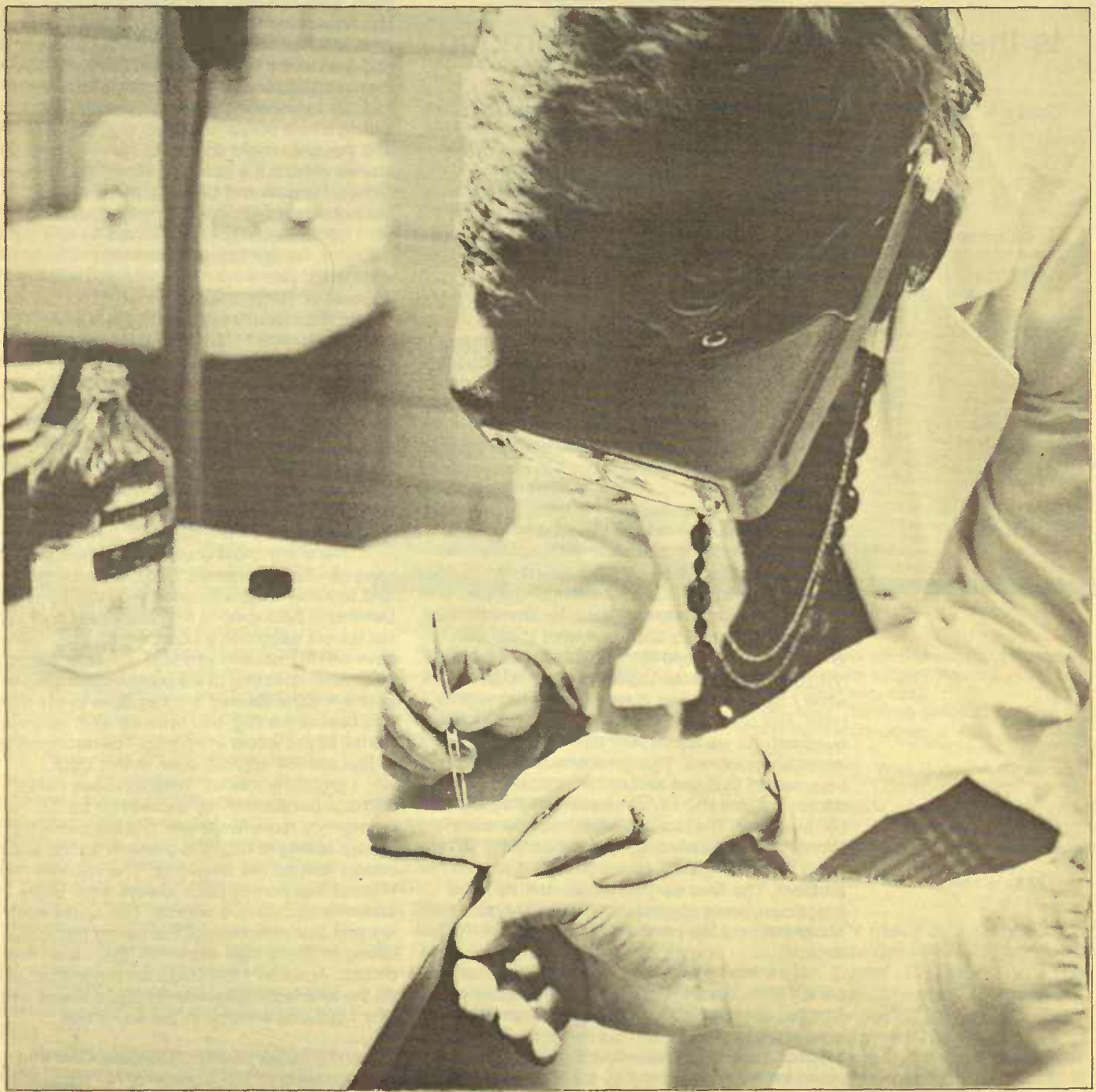
In situations like these tact is crucial. I try to tackle the immediate problem first and, later, talk about what to do the next time. Judgment, scolding, or ridicule only leads to guilt and embarassment. Not all of my experiences end in trips to the hospital. Often I just answer questions that people feel awkward asking their doctors — like what to feed a child with the flu or could those funny red spots on Johnny's back be Chicken Pox? If an injury or illness looks serious or requires more than basic first aid I refer them to their physician.

One of my most challenging cases involved a two-year-old male named Otto. About six inches tall and two feet long, with short red hair, he is a Daschund belonging to the family next door. When his tail got caught in a door, the tip was neatly severed. My nearly hysterical neighbor called for help. After speaking to the pup's veterinarian on the phone, I administered a tranquilizer to my friend, a little beer to the dog, and dressed what remained of the tail as you would a finger tip. The basic principles of first aid still applied, even in this case.

I enjoy my role as "neighborhood nurse", perhaps because of my experience as an emergency room nurse and first aid instructor. I am always willing to help if a problem arises and the people around me know this. The children have learned that nurses don't always wear white uniforms and carry a needle. The adults have learned that members of the caring profession are willing to share their expertise, even after five o'clock. And me? I feel I reap the biggest benefits of all, the satisfaction that I have helped others, which is why I became a nurse in the first place.

Susan Nau Steidl lives in Lexington, Ohio and is a graduate of the College of Nursing, University of Florida, Gainesville, Florida. She was co-author of an article based on her experience in pediatrics during her student days and published in The Canadian Nurse *ten years ago. Now, she says "I am once again turning my thoughts towards writing for publication after taking time out for marriage and raising a family."*

The Occupational Health Nurse



Photos by Suzanne Emond

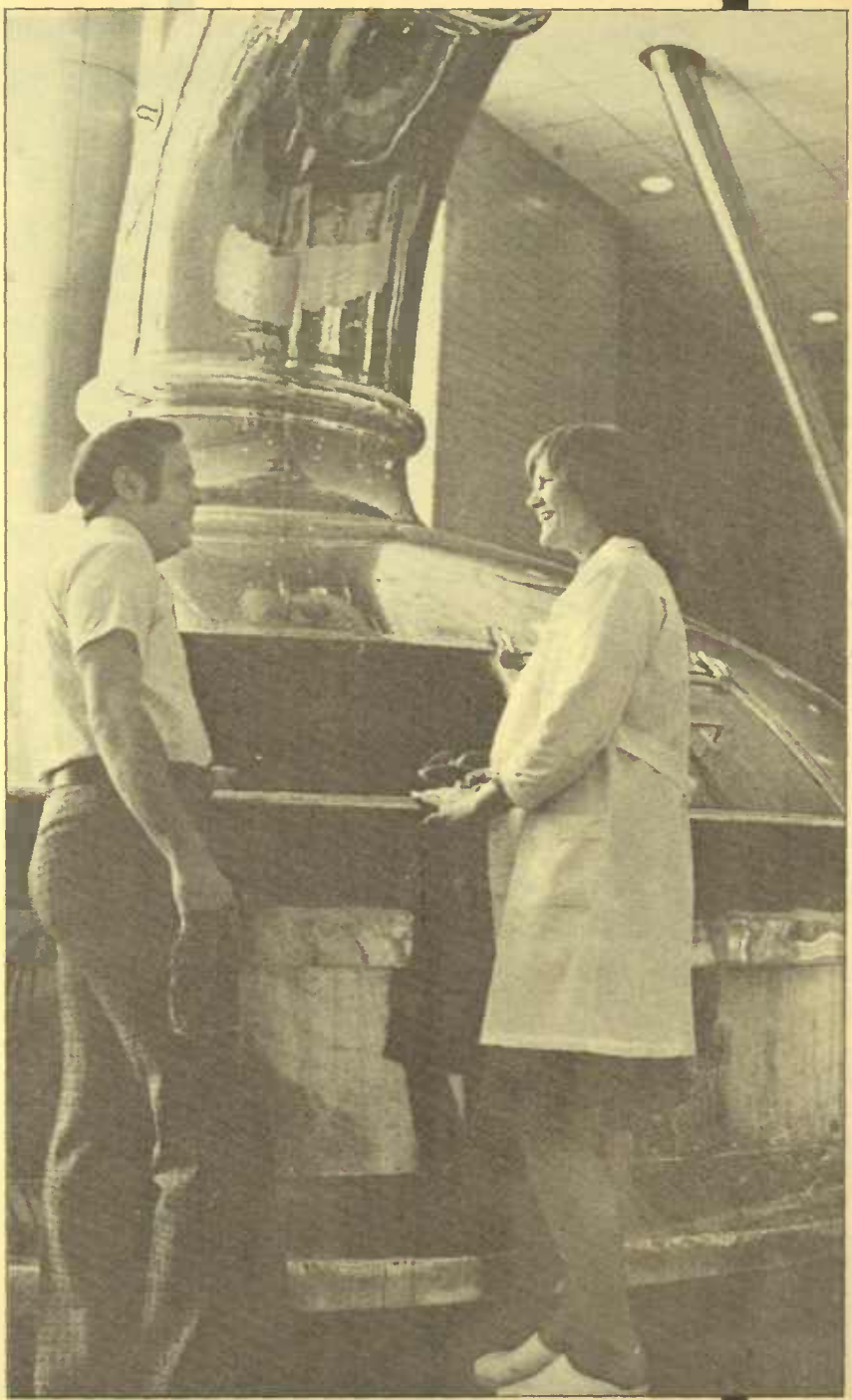
A survey of the existing qualified manpower pool reveals that occupational health is still very much in its infancy in this country. Right now, there are probably fewer than 2,000 nurses in the whole of Canada who classify their job as that of occupational health nurse. Nevertheless, for the nurse who does enter this field, there are, as this author points out, many specific contributions she can make to improve health and safety in the work environment.

n the Work Environment

Miriam J. Hayman

When it has its full complement of members, the occupational health team includes representatives of four professions — a nurse, doctor, industrial hygienist, and safety officer. In practice, the size of this team varies, depending on the scope of the program being conducted within a given industry, firm, or government agency and on the size of that establishment. Most large national and international companies have well developed programs and employ qualified staff to manage them. However, 85 - 90 percent of Canadian industries employ fewer than 500 employees and it is not always financially feasible for them to employ the entire team on a full-time basis. For this reason, the role of the nurse, as the professional most likely to be in close and continuous contact with the workers she is employed to care for, is crucial to the success of the occupational health program in many industries. As one observer commented: "Success in health programs depends upon the ability of nurses not only to work independently but also to bring in others as needed to achieve continued good health and safe working practices of employed persons."[1]

It is unfortunate, therefore, that at the present time in Canada there is a definite shortage of readily available nurses with occupational health training and experience, willing to accept this role in which treatment assumes a back seat to prevention[2] and health promotion activities. It is also unfortunate that both health professionals and the general public tend to view industrial health programs as the nurse putting on Bandaids* and the doctor doing medical examinations. Most of the literature describes the basic occupational health nurse's functions as: treatment, counseling, health promotion and education activities, screening programs, physical assessments, assessing illness absenteeism and maintaining reports and records. Few references can be found to the nurse's role in relation to the work environment. Whether she is working in a large industry with the full occupational health team or a small company with one nurse, how could any nurse expect to function effectively without a good knowledge and understanding of the conditions, processes and problems affecting the



On-the-job at the Richard L. Hearn Generating Plant operated by Ontario Hydro, Maureen Townsend (opposite page) removes a splinter from the hand of one of the plant's employees. Above, Nadine Franks (cover) learns more about the equipment at the plant where she works from the project engineer.

** Bandaids is a registered trademark of Johnson and Johnson Limited.*



Protective devices and safety equipment are important factors in reducing health hazards and both nurse Townsend and her fellow worker above wear helmets, safety glasses and hearing protectors.

employee groups in the work locations?

What about the work environment? What should the nurse be doing in this area and why? To some extent her role depends on what other members of the occupational health team are available to work with her, but regardless of this, the first thing she must do is to make regular visits to all the work areas in the plant. During these visits the nurse has an opportunity to observe and learn many things about what goes on in the work environment, knowledge that will have a direct impact on her own effectiveness in dealing with health and safety problems that the ill or injured employee presents at the Occupational Health Unit. There are many reasons for the nurse to visit the work area. Eight of these reasons follow.

1 *To become familiar with the body mechanics required of each occupational group — bending, lifting, kneeling, reaching, standing, etc.* This information is valuable in appraising the cause of physical symptoms but it is also necessary when assessing an employee's fitness to return to work after an illness or accident. Possibly the employee will require a period of rehabilitation before returning to his regular job.

2. *To become familiar with the health hazards that exist in the work area — solvents, dusts, gases, noise, radiation, toxic chemicals, etc.* The nurse in this situation must be aware of the body portals for the various toxic substances as well as the physical signs and symptoms of occupational illness and disease. This essential information facilitates earlier recognition of health problems, enabling more prompt medical treatment. It should generate a need for inspection and evaluation of the problem at the work site. Remedial action in the form of improved control methods[3] should be the final result.

3. *To become aware of new processes as they are developed and initiated.* New processes can mean new problems and an alert nurse researches the possible toxic agents in order to be prepared for potential problems. Sometimes these problems can be eliminated before the process becomes operational.

4. *To become familiar with the protective devices and equipment used to prevent*

illness or accidents. The nurse then can use the pre-employment interview to encourage a new employee to utilize all the protection available. She can also reinforce the need to use protection in her contacts with other employees who sometimes tend to become careless or over-confident.

5. *To observe unsafe conditions and unsafe practices.* The nurse, as a member of the safety committee, has a responsibility to assist in reducing the frequency and severity of industrial accidents. Problems should be reported to supervisors and the safety committee. As well, a tactful word on the spot to a forgetful employee can result in immediate use of available protection.

6. *To maintain regular contact with foremen and supervisors.* This assists in building good rapport and enhances the mutual understanding and cooperation necessary for a team effort to improve health and safety.

7. *To enable accurate, appropriate referrals.* The six previous items constitute the major reasons for visits in the work areas, however, there is another important reason — accurate appropriate referrals to doctors, industrial hygienists and safety officers — the other occupational health team members.

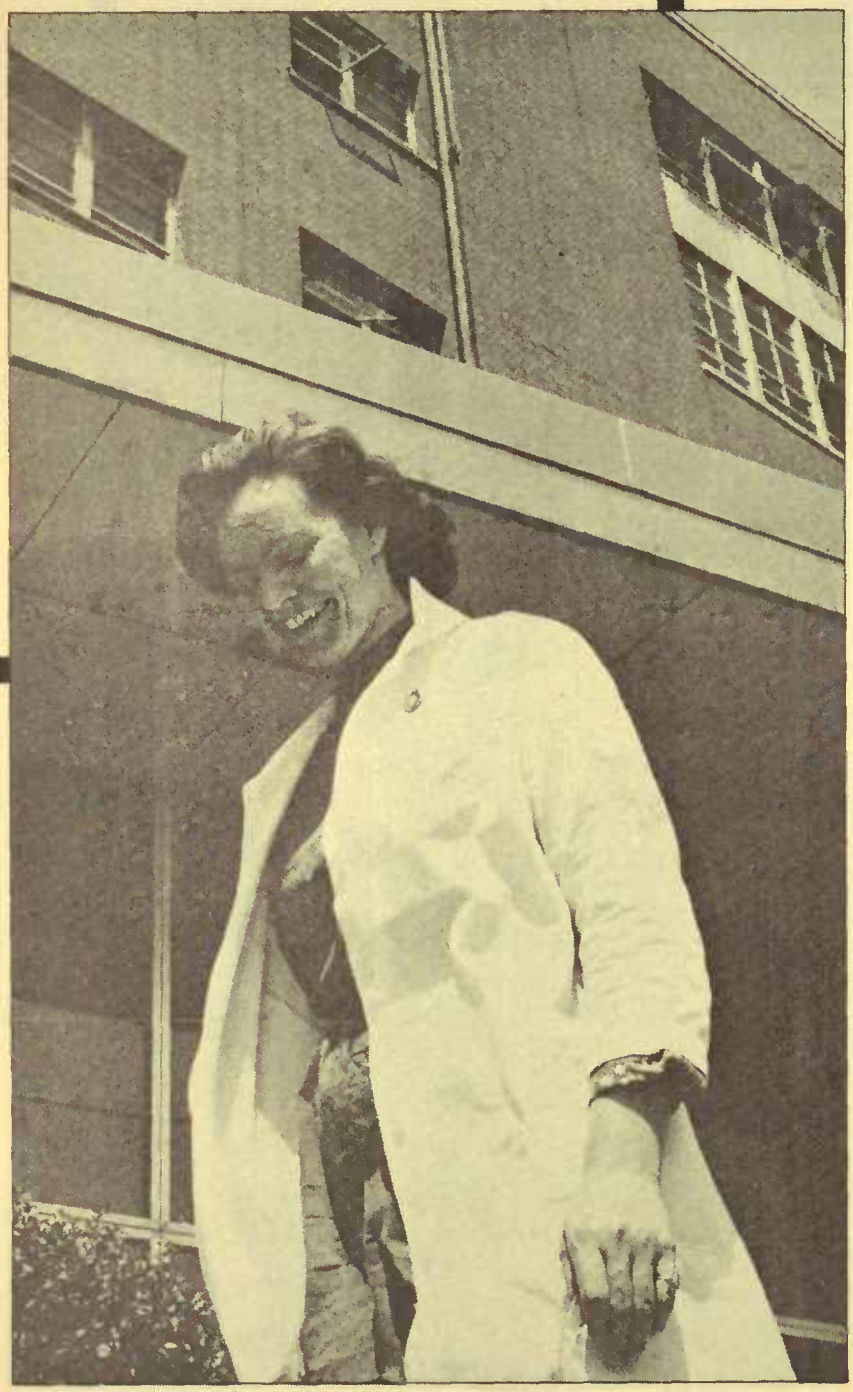
8. *To observe basic hygiene and sanitary conditions as well as inspect emergency rooms and first aid supplies.* These reasons may seem elementary but unfortunately they are still necessary in most companies.

Conclusion

There is ample evidence today to support the theory that we are in the midst of an "environmental revolution." Almost daily, the media reports activites of small groups across the nation who are endeavoring to gain public support in their fight against environmental pollution. Public concern over the quality of the air we breathe, our waterways and the landscape around us, has brought about government action on some environmental issues. Unfortunately, no corresponding degree of public concern has developed regarding the work environment, even though it is recognized that many health and safety hazards do exist. Governments, industry and the unions have neglected this area. Even



A tour of the work area leads to greater understanding for Nadine Franks of the hazards that exist for the worker.



treatment oriented health professionals have paid little heed to the effects of the work environment on the physical and emotional health and well being of their patients.

None of the occupational health team members work in isolation: each of them has a role to play in relation to the work area. What does seem clear, however, is that "the nurse with a high index of curiosity can be the most valuable co-worker that the occupational health physician and industrial hygienist can have. She is management's most sensitive indicator of potential people or environmental problems."[4]

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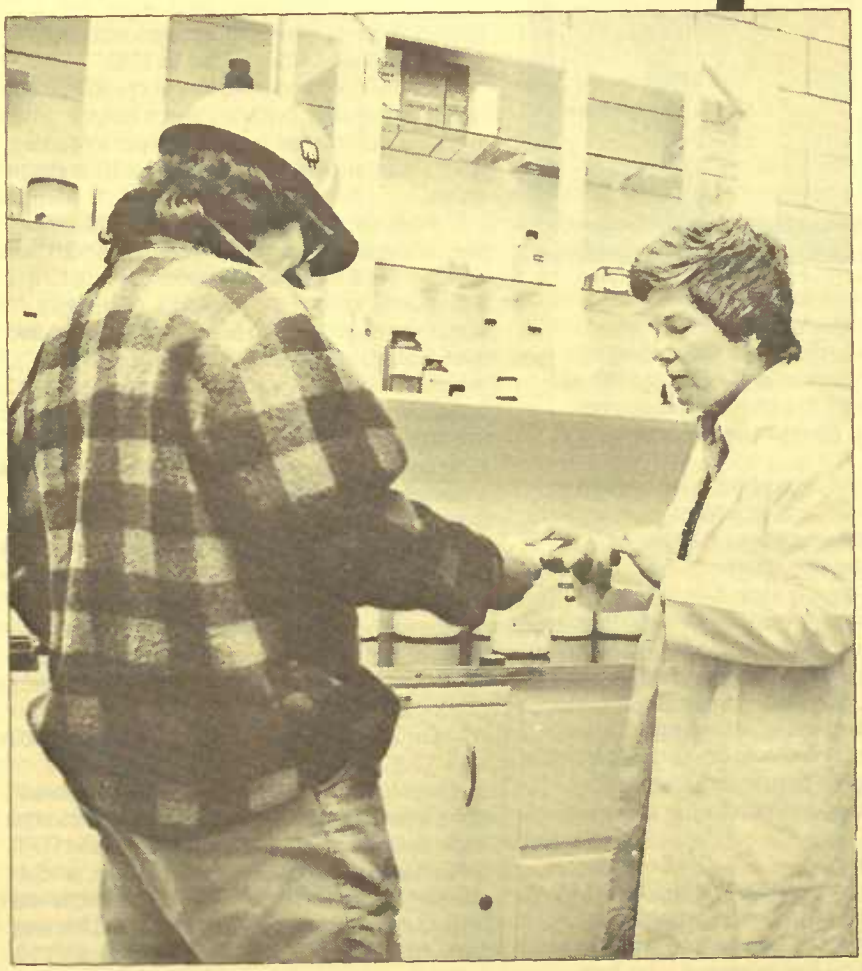
Miriam Hayman, who writes about the role of the occupational health nurse in the work environment, is presently employed as Regional Nursing Officer, Atlantic Region, Medical Services, Health and Welfare Canada in Halifax, N.S. She is a graduate of Payzant Memorial Hospital in Windsor, N.S., received her P.H.N. and D.N.S.A. from Dalhousie University in Halifax and holds a Certificate of Occupational Health Nursing from the American Board of Occupational Health Nurses. The article formed the basis of a paper she presented to delegates to "Occupational Health: Issues and Priorities," sponsored by the Canadian Public Health Association and held in Toronto last winter.

Editor's Note:
The term "occupational health" was first used officially in 1950 by the World Health Organization/International Labor Organization expert committee on Occupational Health. The committee stated

that "Occupational Health should aim at the promotion and maintenance of the health of workers in all occupations."

The first nursing organization to use the name "Occupational Health Nursing" was the Royal College of Nursing in London, England, which has offered a Certificate in Occupational Health Nursing since 1954.

Short-term course records in the CNA Library indicate that courses in Occupational Health Nursing are available in this country at Grant MacEwan Community College in Edmonton, Alberta (two trimesters) and at the Faculty of Nursing, University of Toronto (5 days).



Clinical Wordsearch

Answers

1 Laparotomy
2 Cholescystectomy
3 Paralytic ileus
4 Colostomy
5 Levine
6 Electrolytes
7 Sutures
8 Dressing
9 Aseptic
10 Hysterectomy
11 Catheter
12 Analgesic
13 Antibiotic
14 Transfusion
15 Scultetus
16 Distention
17 Pancreatic
18 G I series
19 Hyperalimentation
20 Appendicitis
21 Serum
22 Clips
23 Anaesthetic
24 Colectomy
25 T-tube
26 Preop
27 Pain
28 Shock
29 Navel
30 Prn
31 M.V.A.
32 I.V.C.
33 N.P.O.
34. Laporoscopy
35 O.R.
36 Scan
37 Skin
38 BRP
39 Ulcer
40 Ileum
41 Pale
42 T.I.D.
43 S.O.B.
44 O.D.
45 Scar

Hidden Answer: Surgical Nursing

The puzzle on page 13 is one of a series submitted by Mary Elizabeth Bawden (R.N., B.Sc.N.), who began constructing puzzles originally for use in staff education. Bawden is an active member of the Registered Nurses' Association of Ontario, and presently works as Team Leader in the Rheumatic Disease Unit, University Hospital, London, Ontario. When she sent the puzzle in, Bawden wrote, "I think it would be fun for the readers of The Canadian Nurse *to have a puzzle...." Hope you enjoyed it!*

Disseminated Intravascular Coagulation: A patient profile

Joyce Granberg, R. Lowndes, N. Robinson, M. Busslinger, D. Bunch, J. Palmer, Y. Weitzel, M. Johnston, W. Bowes, M. Kenny, J. Harvey, B. Burden



Figure 1 — Right forearm showing eccymotic skin lesion.

The treatment of any critically ill patient involves the utilization of all the resources a hospital has to offer. The resources of emergency, medical and nursing staff are taxed to provide the best care possible, hopefully both physiologically and emotionally.

The patient described here arrived in emergency in critical condition. A few years ago, her symptoms might have been misdiagnosed since disseminated intravascular coagulation has only recently been recognized as a clinical entity. Improved understanding of the pathophysiology underlying DIC has brought about more frequent detection and, in this case, resulted in appropriate diagnostic tests and treatment. Careful nursing observation and intervention were essential in preventing further complications and in aiding her recovery.

The Patient

In emergency department... Mrs. Monty, a 24-year-old woman, was admitted to emergency at 0620 hours. She was accompanied by her husband who had awakened to find her cold, clammy and mottled. At the time of admission, she was conscious but confused, with poor color and blotchy limbs. Her vital signs were: BP 58/40 mm Hg., apex 100 beats per min., no palpable peripheral pulses and an oral temperature of 36° C. Within one hour, her diastolic pressure had dropped to 30 mm Hg. and her apex had increased to 160 beats per min.

Immediate treatment included the administration of oxygen at 6 liters per min. via nasal cannula, insertion of an IV via cutdown, through which Sodium Bicarbonate and Solucortef were given, and the insertion of a Foley catheter. Hourly urine output and vital signs were recorded q 15 minutes. A throat swab as well as specimens of blood, urine and stool were sent for culture and sensitivity. Venous and arterial blood was drawn for blood gas analysis. By 0800 hours, Mrs. Monty's vital signs were: temperature 39°C rectally, apex 112, respirations 28 per min., BP 50/40 and adequate hourly urine output. After the attending physician had spoken with her family, she was transferred to ICU.

Mrs. Monty's past history showed that she had been healthy until two years before, when she had contracted a urinary tract infection which was successfully treated with sulfa drugs.

Four months prior to this hospitalization, she developed a vaginal discharge which was resistant to therapy. One week before admission, she had symptoms of nausea, vomiting, diarrhea and fever, and was treated with Gantrisin. Further treatment with Ampicillin and Gravol for a urinary tract infection was commenced. The only other medication she was presently taking were birth control pills. She was described as being a social drinker and smoked approximately one package of cigarettes a day.

Diagnostic Tests: "DIC is not usually hard to diagnose. Coagulation screening tests are markedly prolonged in addition to severe thrombocytopenia, hypofibrinogenemia, marked deficiencies in prothrombin, factors V, VIII, and elevated levels of fibrin degradation products."[1]

On admission, Mrs. Monty's hemoglobin was 13.8, white blood count 16,000, sedimentation rate 7. A coagulation screen done later that day showed markedly elevated fibrin split products, a prolonged PT and PTT, a fibrinogen titre of 67 mgm percent, and a platelet count of 16,000. Her initial BUN was 56 and this eventually rose to 192. A CPK was over 10,000 units and her SGOT was 1710 units. A urinalysis showed bilirubin, hemoglobin, and myohemoglobin in the urine. Cultures of the throat, blood, cervix and cerebrospinal fluid were negative. A lumbar puncture showed no abnormality. On the basis of her blood results, a diagnosis of DIC was made(See Table 1).

Table 1

Results of Mrs. Monty's diagnostic tests

Hematology and Biochemistry tests	Admission	Day 1	Day 2	Day 3	Day 4	Normal values at the Calgary General Hospital
Prothrombin Time	27.9		24.1	17.8	17.1	(11.5 — 14.5 sec.)
Partial Thromboplastin Time	143.2		5 min.	88	70	(35 — 45 sec.)
Platelets	16,000		26,000	16,000	11,000	(200,000-350,000/cu mm)
Fibrinogen Titre	67	66	66	67	50	(200-400 mgm percent)
Fibrin Degradation Products	40		40			(40 ug/ml)
Bleeding Time			6			(2 — 6 minutes)
Sodium	130	133	130	119	122	(135-145 mEq/liter)
Potassium	4.8	3.9	3.9	3.8	4.9	(3.8 — 5.0 mEq/liter)
Chloride	98	91	87	82	83	(136-148 mEq/liter)
BUN	56	67	95	148	100	(5-20 mgm)
Creatinine	5.4	5.4	6.5	7.7	9.4	(0.7 — 1.5 mgm)

Therapy

On arrival to ICU at 0800 hours, Mrs. Monty was suffering from shock and fever. A stat dose of IV Solucortef 500 mgm and IV Kanamycin 1 gm were given. IV Solucortef was then given q6h. Other IV antibiotics, Clindamycin, Cloxacillin and Kanamycin, were started immediately. Dextran, albumin and plasma, which act as plasma expanders, were also used as an adjunct in the treatment of shock.

Because the use of anticoagulants in this disease is very controversial, it was initially decided to withhold large doses of Heparin in the absence of clinical bleeding.

Twenty-four hours later, Solucortef was reduced to 100 mgm q8h because of increased capillary perfusion. A biopsy was done of ecchymotic skin lesions on the right forearm (See Fig. 1) which showed two gram negative diplococci. This raised the question as to whether meningococcus was the causative organism. However, since Mrs. Monty had been given Ampicillin prior to admission, only one meningococci organism was found in the blood culture.

A vaginal examination done at this time showed a severely inflamed cervix containing approximately 60 mls of pus. Prior to admission, Mrs. Monty had had a yellow-white discharge for several months which had been resistant to treatment. The causative organism of this persistent infection was not determined.

Forty-eight hours after arrival to ICU her vital signs were returning to normal but her urine output had dropped, reflecting insufficient intake. She was edematous due to the intravascular coagulation in the microvascular bed which was reflected in profound hepatic, renal and skin damage. The plan of treatment was to increase fluid intake in view of her decreased urine output. She was again treated with Rheomacrodex (Dextran 40), albumin and saline to try to increase the amount of intravascular fluid. She was continued on steroids and wide antibiotic coverage. This resulted in a rise in her blood pressure and urine output to normal levels.

By the third day, her PT and PTT were returning to normal but her platelet count was still only 16,000/cu mm. There were no sites of active bleeding and the skin lesions were resolving. However, she had developed an acute renal failure complicated by hepatic failure, both of which were secondary to the effects of DIC. Her BUN was rising and myoglobin and hemoglobin were found in her urine, factors which were thought to be contributing to the development of a lower nephron nephrosis.

On consultation with a urologist, it was decided that the first priority was to correct her electrolyte imbalance before proceeding with dialysis. In view of her serum sodium level of 119 m Eq per liter, she was given 600 mls of 3 percent Sodium Chloride IV. However, by the fourth day her serum creatinine was still rising and had reached 9.4 mgm while the serum sodium increased only to 122 mEq per liter. She still showed a marked thrombocytopenia with a platelet count of 11,000/cu mm and a fibrinogen level too low to be recorded. There was no evidence of any massive bleeding, although she was bleeding from her gums. It was thought that her platelet depression was due to renal failure. She was continued on steroids but the antibiotics were discontinued. She was unable to regenerate prothrombin due to her hepatitis, and was given a dose of Vitamin K. In view of the continuing deterioration of her renal function, dialysis was indicated and she was transferred to another hospital.

Follow-up

One month after her transfer, Mrs. Monty was readmitted to the Calgary General Hospital for a prolonged program of rehabilitation to correct mononeuritis multiplex with flexion contractures in her fingers, and foot drop. These complications were probably a result of the excessive swelling of her extremities which had made passive joint exercises impossible. By this time, a series of hemodialysis treatments had reversed her renal and liver failure. After one month of rehabilitation, she was discharged home but continued with physiotherapy as an outpatient. It is expected that she will regain full use of her fingers and that the foot drop will be corrected.

▷

The Disease

The term "disseminated intravascular coagulation" means diffuse or widespread coagulation within arterioles and capillaries all over the body. DIC, also called consumption coagulation or defibrination syndrome, is a complex and important coagulation disorder characterized by two apparently conflicting sets of manifestations: clot formation and hemorrhage (See Table 2).

DIC is not a primary illness but, rather, occurs as a response to a wide variety of diseases (See Table 3). The underlying disease causes tissue injury which results in the release of thrombin into the circulation. Thrombin catalyses the formation of fibrin, and fibrin deposits form throughout the small vessels. This diffuse clotting results in clotting factors being consumed more quickly than they can be replenished by the liver. The presence of fibrin activates the fibrinolytic mechanism by which fibrin is broken down into fibrin degradation products, thus interfering with normal clotting. Therefore, the patient develops bleeding tendencies despite his hypercoagulated state (See Table 2).

Although the specific cause of DIC is unknown, approximately 50 percent of diagnosed cases are associated with mothers with obstetrical complications while another 33 percent of cases are related to terminal cancer.[2] Another common disorder associated with DIC is gram negative septicemia.

Most patients demonstrate signs of impaired function of at least one organ system, caused by the occlusion of small blood vessels in the brain, kidneys, heart and other organs leading to microinfarcts and tissue necrosis.

Signs and Symptoms

The onset of DIC is usually acute; manifestations may be either mild or extremely severe. Symptoms include the following:

- petechiae and ecchymoses on the skin, mucous membranes, heart lining, lungs, etc.
- prolonged bleeding from a venipuncture
- severe, uncontrollable hemorrhage during surgery or childbirth
- oliguria and acute renal failure
- convulsions and coma which may terminate in death.[3]

Treatment

The priorities in the clinical care of a patient with DIC are directed towards:

- the treatment of the underlying disease or problem e.g. shock, delivery of a fetus, irradiation of cancer
- the reversal of clotting. (The use of Heparin is controversial. By slowing clot formation which, in turn, slows the depletion of clotting factors from the circulating blood, Hepann indirectly decreases hemorrhaging) and
- the control of bleeding and shock. Blood transfusions may be administered to replace blood loss, and human fibrinogen is sometimes used in cases of severe fibrinolysis. Care must be taken, since human fibrinogen may cause hepatitis.

Prognosis

Prognosis generally depends on the severity of the bleeding and the amount of organ damage sustained. Severe bleeding is associated with an ominous prognosis if it occurs in three or more sites. It has been estimated that two-thirds of patients with DIC die in the hospital.[4]

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3 Ibid p. 799.

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Table 2

Normal Coagulation	DIC
— contact of circulating blood with a roughened surface due to vessel injury	— extensive tissue damage ↓
— platelets split releasing platelet factor III.	— extensive coagulation ↓
— platelet factor III, in the presence of other blood proteins and Ca++forms active tissue thromboplastin	— depletion of clotting factors ↓
— thromboplastin reacts with prothrombin and Ca++to form thrombin.	Hemorrhage
— thrombin activates the formation of fibrin from fibrinogen to yield fibrin clot	
Normal Fibrinolysis	
— presence of fibrin activates enzyme fibrinolysin	— extensive coagulation results in extensive fibrinolysis ↓
— fibrinolysin causes fibrin clot to disintegrate	— large amounts of fibrin degradation products released ↓
— fibrin degradation products are released	— some fibrin degradation products interfere with normal coagulation ↓ Hemorrhage

Carrigan, J.J. Jr. "Heparin Should be Used Cautiously and Selectively" *Internal Medicine*, 1974, pp623-632.

Table 3

Underlying diseases associated with DIC

Septicemia (due to)

gram negitive bacteria
virus
fungus
rickettsia
protozoa
snake venom

Complications of Pregnancy

toxemia of pregnancy
abruptia placenta
fetal death in utero
amniotic fluid embolism
uterine rupture

Carcinomas

prostate
stomach
pancreas
acute leukemia

Surgical procedures

lung surgery
open heart surgery
renal homograph rejection

Hemolytic disorders

thrombocytopenia purpura
purpura fulminans
polycythemia vera
hemolytic transfusion reaction
hemolytic uremic syndrome

Other problems

allergic reaction
burns
trauma
shock
pulmonary and fat emboli
dissecting aneurysm
cyanotic heart disease
liver disease



Team effort pays dividends: *Some of the ICU nurses at Calgary General Hospital whose combined talents resulted in the publication of "Disseminated Intravascular Coagulation" got together recently to have this picture taken. From left to right they are: Row one - M. Kenny, D. Bunch, J. Granberg, J. Harvey, B. Burden. Row two - W. Bowes, J. Palmer, N. Robinson. Not present when the picture was taken were: M. Johnston, Y. Weitzel, R. Lowndes and M. Busslinger.*

After working together in ICU caring for "Mrs. Monty" (a fictitious name), they decided the case had some unique features that would make it worthwhile for other nurses to read about. We thank them for sharing this learning experience and invite other groups of nurses to consider doing so too. Do you have an interesting case to share?

Nursing Care Plan for Mrs. Monty

	Problem	Goal	Nursing Intervention for a patient with DIC
1 a)	Apprehension and worry about her sudden and serious illness and about her child's welfare.	Relief from apprehension	1. Assign the same nurse to care for Mrs. Monty to establish continuity of care and a trusting relationship between nurse, patient and family. 2. Give Mrs. Monty the opportunity to verbalize fears by telling her that you have time to listen. 3. Give explanations for signs and symptoms and for treatment measures taken. Before proceeding with any treatment, explain: — what the treatment is — what she can expect to feel — how she can help with the treatment.

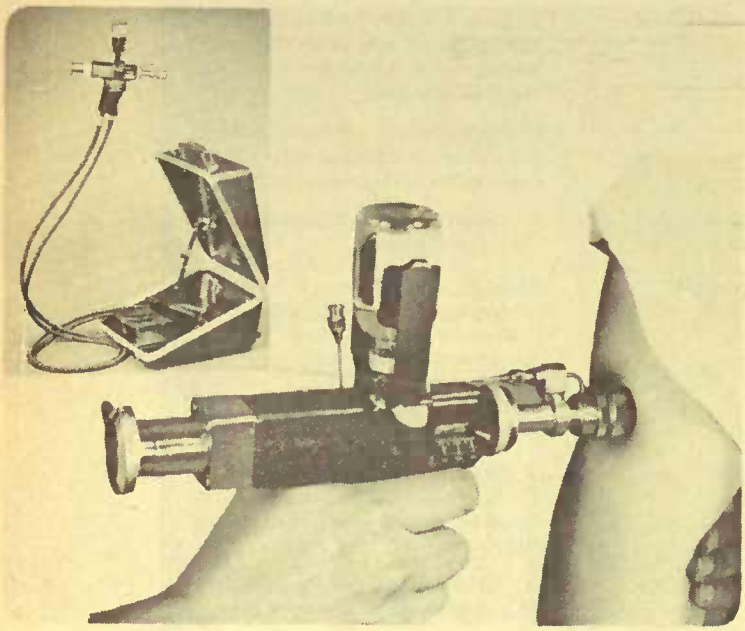
	Problem	Goal	Nursing Intervention for a patient with DIC
b)	Apprehension of the family expressed by verbalizing anger at the hospital staff for "letting her get sick."	Relief from apprehension	1. Provide explanation to family concerning Mrs. Monty's condition. 2. Suggest ways that Mr. Monty might participate in the care of his wife e.g. reading, helping with meals.
2	Hemorrhage into joints, muscles and mucous membranes.	Recognize and control bleeding	1. Observe for signs and symptoms of: *External bleeding* — oozing from any puncture site *Internal bleeding* — restlessness, agitation, ↓ BP↑ P, low hematocrit and hemoglobin, petechiae (demarcate with pen marks), lab results indicating kidney or liver dysfunction, X-rays showing fluid collection. 2. During bleeding episodes • apply cold compresses to the bleeding site for 5 minutes q1h • apply gentle pressure to the site by completely covering the site with telfa to prevent sticking then place an ABD pad over this and secure with Kling • allow Mrs. Monty to rest quietly without moving while bleeding is occurring • any clots that have formed should not be disturbed 3. Measure abdominal, arm and leg girth q8h. 4. Auscultate lungs to assess for fluid buildup. 5. Check urinary output q 1h. If lower than 30 cc/hr, report to physician.
3	Skin damage due to hemorrhage in the form of: 1. swelling 2. stiffness 3. sloughing and blistering of skin	Minimize amount of skin damage	1. Apply padding to side rails with flannelette sheets to prevent trauma. 2. Use small gauge needles when giving injections or inserting I.V. Lab work should be restricted to only necessary tests. Apply pressure to injection site. 3. Maintain skin and mucous membrane integrity by: • rinsing her mouth with mild cleansing solutions, e.g., diluted H_2O_2, using soft applicators q1h. • lubricating her lips with vaseline q1h. • washing her skin with a mild soap, e.g. Ivory, daily and massage all pressure points with hospital dermassage after turning q2h • with onset of jaundice, no soap should be used as it causes itchiness • supporting all limbs and back with downy pillows • giving her soft foods with every meal and pushing fluids — 4000 mls in 24 hours.

	Problem	Goal	Nursing Intervention for a patient with DIC
4	Complains of severe pain upon movement due to bleeding into muscles of arms, legs and joints.	Relief from pain	1. Give analgesics as ordered. 2. Relieve pressure of bedding by using a footboard. 3. Carry out passive range of motion exercises very gently with arms and legs before turning q2h. 4. Use an alternating air mattress. 5. Explain that in the long run, not turning her will add to her discomfort making her skin sore and her arms and legs cramped. 6. Assure her you will be as gentle as possible and encourage her to help by keeping her body relaxed and limp. 7. Always have two or three nurses to carry out the turn.
5	Suffers fatigue, weakness and dyspnea physiologically due to a decrease in erythrocytes causing a reduction in the 0_2 carrying capacity of the blood.	Fatigue and weakness will be kept at a minimum.	As much as possible, 1. Arrange her nursing care to allow for rest periods of 30 minutes *after any form of treatment that involves moving her*, e.g. bed bath, turning, X-ray etc. 2. Allow rest periods in the morning, afternoon, and evening and allow her at least 4 hours of undisturbed sleep at night (conditions permitting). 3. Tell Mrs. Monty that you want her to let you know when she feels tired. 4. Elevate the head of the bed 60° and put pillows behind her head and under each elbow to support her in the semi-Fowler's position. 5. Give her 0_2 therapy as prescribed for dyspnea.
6	Disorientation to time, place and person. Increasing restlessness.	Protection from self-injury. Increased level of orientation. Decreased restlessness.	1. Keep room as quiet as possible e.g. put a sign at the base of her bed in large letters "Quiet Please — speak slowly to patient." 2. Give simple and brief explanations before all procedures. 3. Orientate her often to her surroundings and be alert for increasing confusion. 4. Keep side rails up at all times. Use soft restraints, e.g. ABD pad, with Kling only as a last resort. If restraints are used, check q2h for adequate circulation (check color, warmth and movement of hands). 5. Check Mrs. Monty as least q30 minutes. 6. Explain to the family, the reason for her confusion, the precautions being taken and how they can help to orientate her.

* Problem-oriented nursing care plan used at the Calgary General Hospital, adapted from Mayers, M.G. *A Systematic Approach to the Nursing Care Plan*. New York, Appleton-Century-Crofts [1972].

Information is supplied by the manufacturer; publication of this information does not constitute endorsement.

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"Ped-o-jet" Injectors for Swine Flu Vaccine

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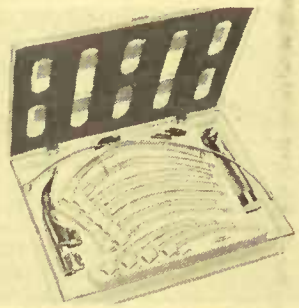
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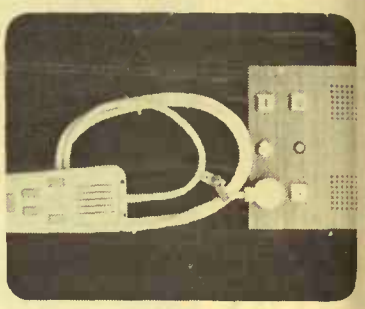


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The Canadian Nurse

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Nurses running for the health of it Early risers in Halifax during the recent CNA annual meeting included this group of RNAO members who started each day with a few laps around the park. Sporting T shirts boosting the national association's next biennial meeting in Toronto in 1978, are: (left to right) Kay Glennie, Debbie Harding, Barbara Brown, Donna Rowe and Gayle Van Horne.

Photographer Terry Waterfield of Wamboldt-Waterfield in Halifax took the cover photo, as well as all others featured in the convention coverage which begins on page 20 of this issue.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses' Association.

ISSN 0008-4581

Indexed in International Nursing Index, Cumulative Index to Nursing Literature, Abstracts of Hospital Management Studies, Hospital Literature Index, Hospital Abstracts, Index Medicus. *The Canadian Nurse* is available in microform from Xerox University Microfilms, Ann Arbor, Michigan, 48106.

The Canadian Nurse welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-space. Send original and carbon. All articles must be submitted for the exclusive use of *The Canadian Nurse*. A biographical statement and return address should accompany all manuscripts.

Subscription Rates: Canada: one year, $8.00; two years, $15.00. Foreign: one year, $9.00; two years, $17.00. Single copies: $1.00 each. Make cheques or money orders payable to the Canadian Nurses' Association.

Change of Address: Notice should be given in advance. Include previous address as well as new, along with registration number, in a provincial/territorial nurses' association where applicable. Not responsible for journals lost in mail due to errors in address.

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Perspective



Guest editorial

It is an honor and a privilege to have been asked to write this editorial as my first duty in the office of president of the Canadian Nurses Association. I shall reflect briefly upon two key issues, one of which is organizational and refers to the operation of the CNA itself; the other is professional and refers to the potential role of nursing in the developing system for the delivery of health care.

Many people have observed that large associations, such as CNA, find it difficult to declare their positions on specific issues. When they do, it may be at a moment when interest is flagging and commitment diminishing.

It is apparent that this situation occurs in part because the organized nursing profession is many things to many people. Varied goals, interests, and responsibilities may result in more inputs into the CNA "system" than it can process or than it can handle in the most logical sequence. In the jargon of the systems analyst this is a condition of "system overload."

What happens when the system is overloaded? Adaptive responses are of two types: to allocate less time to each input or to disregard those of low priority. In both of these responses there lies considerable risk of depriving individual members of a sense of direct contact and spontaneous integration into the professional association. The latter becomes, so to speak, impersonal and irrelevant to each nurse. Moreover, when the association fails to create an integrated position from disparate opinions on important issues we are perceived by related institutions and social organizations as lacking in credibility.

One of the immediate tasks of each new executive working in concert with provincial directors is to develop and articulate a context within which inputs can be absorbed so that the association does not become swamped and ultimately paralyzed into inactivity. Failure to respond in an appropriate manner at an opportune time simply because consensus cannot be reached can seldom be regarded as a virtue even in an imperfect world.

Another issue to which your board must direct itself in this biennium is to more clearly identify th responsibility of CNA members to th citizens of Canada for the development of strategies and programs in the field of family healt care. Notions of family and communit health, while not novel to many nurses, are only now receiving the attention from governments, public bodies, and health care professional that they deserve. Even during the 1976 Convention we were implored t assume a more forceful and dynami presence in this area.

We are cognizant of our need tc explore our potential for family care, tc research issues of individual and family health, and to develop a body o knowledge and set of skills which wi permit us to take a leadership role among health care professionals. W cannot lose this opportunity to make what may be a highly significant contribution to the changing system of health care delivery.

The talent and commitment of the board which you have elected at national and provincial levels augurs well for the type of leadership required to move Canadian nursing in the direction of novel solutions to the problems that will arise during this biennium.

— Joan M. Gilchris

Herein

As this issue goes to bed, we'd like to think that each and every one of you will find something of special interest to read when you get your copy. For those who attended the CNA annual meeting and for those who want to keep up with what their national association is doing for them — there's a detailed picture story on the Halifax convention.

Then, there's a useful information package in the form of an article on "Neurotransmitters and Related Drugs," a look at the controversial and timely topic of amniocentesis in "Dilemma," and one nurse-teacher's approach to problem solving, in "The Sleep Assignment."

Finally, for any of you thinking of brushing up on your continuing ed credits, there's an explanation of the BCIT experience in "Refresher Perspectives," followed by a light-hearted account of what it's like to go back to school in "The Diary of a Retread."

Next month, *The Canadian Nurse* will feature the first in a three-part series focusing on the cardiovascular system — in health and disease. The September issue will include a review of normal cardiovascular development and congenital abnormalities, and a discussion of the role of the nurse in primary prevention of cardiovascular disease. Subsequent issues will deal with emergency treatment, hospital management and rehabilitation of patients with cardiac problems.

If you want to brush up on the fundamentals of cardiology, the September issue of *The Canadian Nurse* should be a good beginning.

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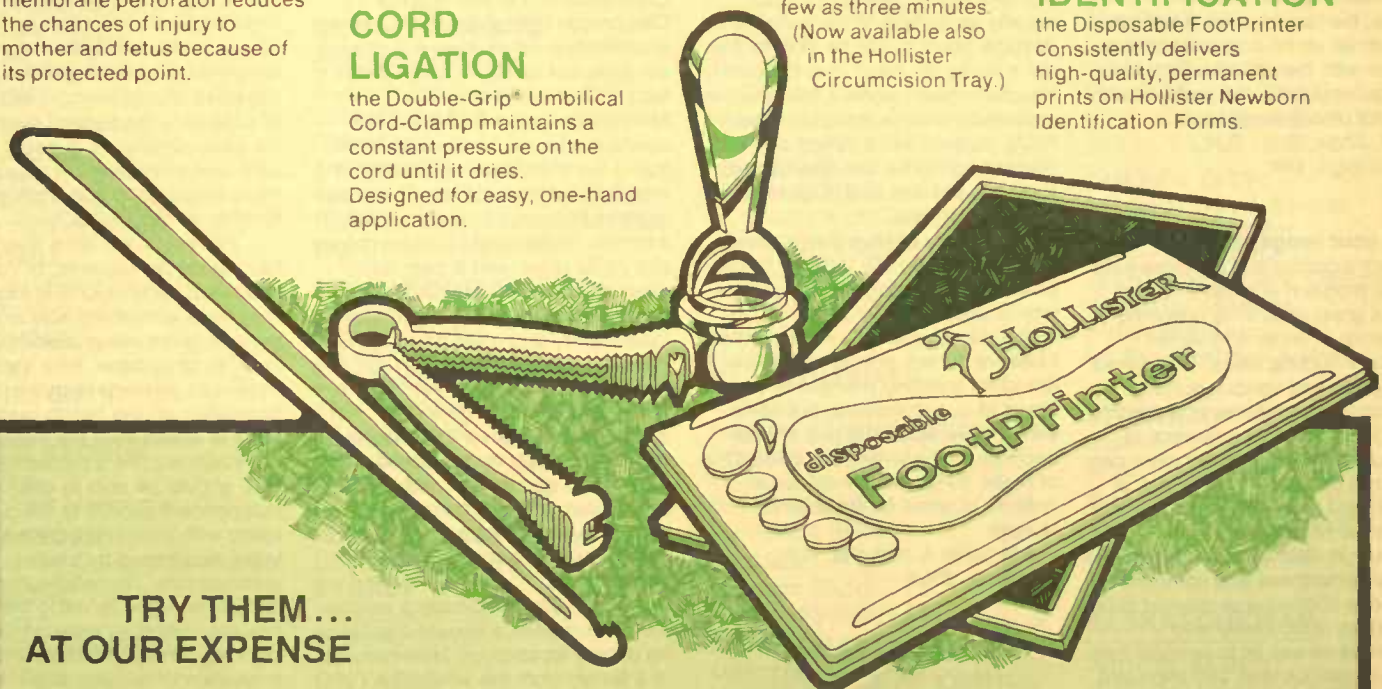
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Input

Caring for the whole client

The public now demands a high quality of nursing care with emphasis on the individuality of the client. To meet these needs, the nurse must assume the following roles: team member, colleague, liaison, generalist, clinical specialist, administrator, researcher, teacher, counsellor, nursing and community leader, and client sponsor and supporter. She must be a flexible person who has a general but enriched education.

What kind of nursing education curriculum can meet these varied needs? First of all, the nurse must be primarily a generalist. Her education should include principles from the humanities, behavioral and bio-medical sciences. The problem with nursing education today is that no connection is made between disciplines. If these subjects are not interwoven and presented as information relevant for assessing client needs, the student will not apply the principles of her education.

The B.N. curricula are mainly centered around varying concentrations of the arts and sciences. There is no doubt in my mind that each orientation is equally important but, because the programs are fragmented, the student often responds by minimizing the importance of interpersonal relationship skills, or emphasizing her interpersonal skills with a minimum of interest in the bio-medical sciences.

Yet, a balance is possible. Rather than debating the concentration of bio-medical sciences or behavioral sciences and humanities in the curriculum, educators should focus on unifying both main branches of knowledge. Thus, the nurse will be able to approach her client using the 'whole person' orientation. Since she is examining man in psychological-sociological-bio-medical terms, she is able to relate with, teach and learn from her client. Because of her knowledge of herself and the 'whole person' in her client, both the nurse and client can experience much satisfaction from their encounter.

If nursing courses could be used to interrelate the principles of the triad of the disciplines, then nurses could cater to the 'whole person.' She would then be a professional who is expert in interpersonal relationships and would be equipped to enhance and enrich the health and lifestyle of her "people."

— Sharron Gallagher, B.N., Montreal, Que.

Handmaidenism rejected

We wish to comment on the article by F. Jo Logan (May, 1976.) We take exception to the suggestion that "nursing educators must retain handmaiden skills in the curriculum until they are not so urgently required." On the contrary, handmaidenism fosters the traditional subservient nurse-doctor relationship and prevents the development of the nurse and doctor working as colleagues for the goal of patient care.

A large part of the mystical power of the doctor is contained in the form and in the carrying out of "doctor's orders." We advocate that doctor's orders be abolished and a "patient treatment plan" instituted. This would encourage all members of the health team to participate in planning, and we would be rid of a large stumbling block to a "colleagueal approach" to patient care.

We need innovative ideas coming from recent graduates and seasoned nurses. There is no direct relationship between creativity and length of service.

— Gail Gitterman, R.N., B.A., Instructor, Nursing Department, Ryerson Polytechnical Institute, Michael Gitterman, B.Sc., M.D., Toronto.

Nurses save lives

The nurses of the Renal Dialysis Unit of the University of Alberta Hospital in Edmonton have undertaken a project to attempt to increase the number of donor cadaver kidneys available for renal transplant. The project is being developed with the support and guidance of the Edmonton Chapter of the Kidney Foundation of Canada. With the approval of the Medical and Nursing Administration of the University of Alberta Hospital, the nurses have organized a program with the following objectives:

— to educate the general public about the need for organ donation and the need for carrying an organ donor card;
— to educate members of the medical, nursing and associated professions about the need for organ donations and the method of preserving and transporting donor kidneys.

We hope to relay the need to the public by poster campaigns (posters to be made by our patients), and by setting up information booths in shopping centers, and at convention and group meetings. We have been asked to conduct inservice sessions at various hospitals and public health clinics and also hope to make use of all aspects of the media — radio talk shows, television news, and articles.

For further information write: The Kidney Foundation of Canada, Edmonton Chapter, Box 1011, Edmonton, Alta.

— Phyllis Kalynchuk, R.N., Edmonton, Alberta.

Special delivery

This is an open letter in appreciation of the library services that the Canadian Nurses Association provides. Recently our ICU group presented a seminar on the various aspects of death. I wrote the CNA librarian, who proceeded to find material for us. The only available material was a tape, on loan from the Medical Services Branch, Health and Welfare Canada. Due to the closeness of the presentation date, the library undertook the cost of responsibility for the tape so that it could be forwarded immediately to us.

— Bev Fortner,(Supervisor), Prince Rupert Regional Hospital, Prince Rupert, B.C.

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Teacher, Editor, Colleague, and Friend

Margaret Kerr



On June 27, 1976, Margaret E. Kerr, editor and executive director of *The Canadian Nurse* for 21 years, died in Vancouver.

Born in Ontario, a graduate of the Vancouver General Hospital School of Nursing, the University of British Columbia, and Columbia University, Kerr left a 14-year teaching position at U.B.C. to become editor of the journal in 1944. At this time, the mailing list for *The Canadian Nurse* stood at 5000 subscribers, and Kerr undertook a vigorous 'selling' program to increase circulation and awaken each CNA member to her responsibility for the journal.

As early as 1944, Kerr discussed the idea of subscription through association fees with the Editorial Board of the journal. By 1949, her idea received approval, and she began to put her campaign into effect. Kerr believed that subscription through fees would stimulate an interest and understanding of recent professional developments for nurses across Canada. Her campaign called for thousands of miles of travel, countless talks and formal addresses on her part, and asked for the approval of the plan by each provincial association. By 1959, a considerably enlarged subscription list told the tale of Kerr's hard work and enthusiasm.

The success achieved by the journal under Margaret Kerr's guidance won for her the admiration of nursing editors internationally. By 1965, *The Canadian Nurse* was reaching 113 countries outside Canada. Her advice and opinions were sought by editors around the world. She was recognized by the journal Board as an able businesswoman, of sound judgment and acute insight. As a public speaker, her warmth, sincerity, and conviction won the approval of many for her cause.

Kerr was also deeply involved in the professional activities of many provincial associations, often in relation to the development of registration acts. Within the CNA, she served as an observant and watchful counsellor.

She was known for a generous nature; open to criticism, willing to compromise, possessing a warm sense of humor.

Kerr's objective was to further the cause of her profession, to develop a body of well-informed nurses. She encouraged them to write so that others might benefit from their experience.

Margaret Kerr will be remembered by many people in many different ways — as a teacher, editor, colleague, and friend.

The "right moment" will doubtless come, when fitting tribute to the life and work of Margaret Kerr may be appropriately attempted. Now, we are too close for perspective; too conscious of loss. Nevertheless, our thought today must be — "Thanksgiving" — for her rich and generous qualities of mind and heart. These are locked into nursing's heritage. They may, confidently, be left "in the lap of time."
Dorothy M. Percy, former Principal Nursing Officer, Health and Welfare Canada.

Margaret Kerr, dear friend and close associate for 11 years. When her counsel was sought, it was given clearly, concisely and cheerfully. We mourn her loss.
Penny Stiver, former executive director of CNA.

To her work with the Journal, as in other facets of her life she brought her vision, the strength of her convictions, a deep sense of commitment, her loyalty, sound judgement and her many personal attributes as administrator, editor and nurse, leavened with humility, sensitivity, and a sense of humor. She was a leader. She helped to make, and herself became a part of, the history of her profession in Canada.
Jean E. MacGregor, former assistant to the editor, CNJ

In view of the fact that she considered French-speaking nurses to be members of CNA in their own right, Kerr wanted them to be informed of the activities of their national association, but she was just as eager to make English-speaking nurses aware of what was happening in the nursing field in Québec. In pursuing this goal, she maintained a remarkable enthusiasm and tenacity.
Suzanne Giroux, former executive director, ONQ.

The Canadian Nurse
from 1905 to 1966

1905 — in March, *The Canadian Nurse* begins publication. Mary Agnes Snively, superintendent of nurses of the Toronto General Hospital, wins support for the idea. The journal begins under the Commercial Press, and the first editor is a doctor, Helen MacMurchy. Minnie Christie, a graduate nurse, is the business manager. The journal is a quarterly publication, with an editorial board composed entirely of nurses.

1907 — *The Canadian Nurse* becomes a monthly publication.

1910 — in May, Bella Crosby, a graduate nurse, is appointed associate editor of *The Canadian Nurse*. Crosby begins to meet with nurses throughout Ontario and in Montreal to stress the national character of the journal and solicit support for it.

1916 — *The Canadian Nurse* is purchased by the Canadian National Association of Trained Nurses (later to become the Canadian Nurses' Association). The editor of the journal is Helen Randall, a graduate of the Royal Victoria Hospital in Montreal. The subscriber list at this time is 1,800.

1924— Randall resigns, with the subscription list at 1,950. Jean S. Wilson becomes executive director of the CNA and editor of The Canadian Nurse.

1932 — CNA headquarters moves to Montreal.

1933 — Ethel Johns of the Winnipeg General Hospital becomes full-time editor and business manager of *The Canadian Nurse*. Johns' concern is with ways to increase subscriptions. She makes changes in the format of the journal and improvements in advertising contracts.

1944 — Johns retires, and the mailing list stands at 5,000 subscribers. Margaret E. Kerr becomes editor, a position she is to hold for 21 years.

1946 — at least one article and releases from the National Office, are to be in the French language for every issue of the journal.

1949 — Kerr begins her campaign for subscription through association fees.

1955 — the first full-time assistant editor is appointed to the journal, as well as a circulation manager and advertising manager.

1958 — Kerr's title is changed to executive director and editor of the journal. Editorial advisors are appointed, with each province appointing one member (two from Quebec).

1959 — in June, the first issue of *L'infirmière canadienne* is published. The mailing list stands at
English: 48,797 subscribers
French: 7,958 subscribers.

1965 — the journal is reaching 113 countries outside Canada. Margaret Kerr resigns as editor. The number of subscriptions has risen to 59,985 English subscriptions, and 14,196 French subscriptions.

1966 —On April 1, the entire CNA operation was centralized in the new CNA House in Ottawa.

The qualities I will remember most vividly about Margaret Kerr are her love of people and the high value she placed on friendship. As a nurse-teacher and editor, these qualities enabled her to give a kind of leadership that developed the individual talents of many nurses. I can think of no higher tribute than to say that she made a lasting contribution to her profession through the personal enrichment of many individuals.
Isobel MacLeod, former CNA president.

Reflecting on the life of Margaret Kerr one is reminded of the advice of the poet, Rilke, to a young girl — "We must always hold to the difficult — in the difficult we must have our joys, our happiness, our dreams." This was Margaret's philosophy which resulted in distinguished service to the nursing profession. Despite serious objections she extended the circulation of *The Canadian Nurse* to every member of the Canadian Nurses Association, and made this publication a truly professional journal. Courageous, forthright, and frank, always a staunch friend, Margaret holds a special place in the annals of Canadian nursing.
Bee Chittick, former nursing consultant, WHO

When I first knew Margaret Kerr, *The Canadian Nurse* carried only a few pages of French texts. In spite of the financial deficit involved in launching a French edition, she struggled to help us attain this goal. Margaret Kerr was a very intelligent and open-minded person.
Alice Girard, former CNA president.

None of us who heard her lectures at Vancouver General Hospital school of nursing can ever forget this vibrant woman who taught us to see that nursing extended beyond the walls of the hospital. She was a nurse who seemed to be free of the stiff restraints of nursing, who lived an exciting life in nursing, and who broke down that barrier between teacher and student with her warmth and enthusiasm.
Helen K. Mussallem, executive director, Canadian Nurses Association.

News



CNA House, symbol of the unity of Canadian professional nursing organizations, now belongs — in fact as well as intent — to the national federation of provincial and territorial associations of nurses across the country.

To celebrate the occasion, a symbolic burning of the mortgage ceremony took place during the recent convention. E.A. Electa MacLennan, who was president of the national association during the 1962-64 biennium when plans for the national headquarters were finalized, presided at the once-in-a-lifetime event. In her remarks to the audience, the former CNA president and life member of the Association reminded nurses that "for more than 50 years, CNA was a tenant in other people's houses, subject to all the uncertainties and limitations of tenant life. I was present and responsible when this debt was assumed on behalf of CNA and it is therefore most pleasant and agreeable to be present when it is committed to the flames."

Nursing Publication and Research Award

The Nurses' Association of the Clarke Institute of Psychiatry, Toronto, has approved a budget of $500.00 a year to be awarded to nurses at the Clarke for nursing research and publication. The Association hopes that the award will encourage nurses at the Clarke to engage in research relevant to nursing, especially in the field of psychiatry. It is also hoped that the award will be a vehicle for opening communication lines between 'psychiatric' nurses and others in the nursing community.

The Association, whose primary role is collective bargaining, stresses the role of professional development and views research and publication as a means to that end.

The Nurses' Association at CIP is interested in knowing if such a program has been undertaken elsewhere and with what effect. They feel that their approach could be an incentive for other groups to institute similar programs. They welcome comments and questions. Contact: *Mrs. J. Stanley, Clarke Institute of Psychiatry, 250 College Street, Toronto, Ontario.*

Support grows for scholarship agency

The Canadian Nurses' Foundation took a new lease on life at its 14th annual meeting this year. Outgoing president, Helen Taylor, pointed out that, when they were elected two years ago, CNF Directors were faced with one major question — is the Canadian Nurses' Foundation a viable organization? This doubt prompted a period of fruitful re-examination before the Board concluded that the CNF still has an important role to play in supporting Canadian nurses in advanced nursing studies. If numbers are any indication, this year's enthusiastic turnout marked strong support for the Board's conclusion.

Efforts by the outgoing Board to trim the budget over the past two years were evident in their report of a $5000 per year drop in operating costs from 1974 to 1975. One austerity measure was the decision to reduce the size of the Board of Directors from nine members to five. A new Board of Directors, elected at the meeting, consists of: Margaret McLean, ARNN (president); Louise Tod, MARN (vice-president); Hester Kernen, SRNA; Shirley McLeod, RNANS; and Barbara Archibald; RNAO.

One particular area of concern discussed by the president, and later worked into a resolution, was the fact that, with the current unemployment situation, post-graduate nurses who have been awarded scholarships often find it difficult to get jobs in their specialty area. At the same time, some areas of nursing such as nursing research and community nursing are experiencing difficulties finding qualified leaders. The suggestion that CNF not limit scholars to work in Canada was countered with a resolution that the CNF Board consider the feasibility of alloting a few scholarships per year to nurses who wish to study in certain priority areas of development in nursing practice.

In the coming year the Board will also review and clarify voting rights and privileges in relation to the various categories of membership. At present there are 805 voting members, 23 sustaining members and one patron. was suggested that the by-law be changed to give the vote to patrons and sustaining members.

The report of the research committee that a grant had been awarded to CAUSN marked the first time CNF had given money to another agency for research. A total of $5000 was voted at the May meeting for CAUSN to undertake research to develop a tool for use in the accreditation of university programs in nursing education.

The award was presented by Helen Mussallem, CNA executive director, at the annual CAUSN meeting in Quebec city in June.

SRNA holds Annual Meeting

The Saskatchewan Registered Nurses' Association elected three new members of Council and a new president during their annual meeting held in Prince Albert in May.

Sheila Belton, assistant director of clinical nursing at the Plains Health Centre in Regina, was elected president of the SRNA for the next two years.

The three council members will also hold office for the next two years. They are: Betty Hailstone, director of nursing at Pasqua Hospital, Regina — president-elect; Margaret J. (Peggy) Rosso, education and research coordinator at the Plains Health Centre, Regina — second vice-president; Jean Keast, director of nursing at Canora Union Hospital, Canora — chairman of the Committee on Nursing.

Dr. Jerome Lysaught, professor at the School of Medicine and Dentistry of the University of Rochester, was the keynote speaker at the annual meeting. His address, entitled Expectation for Nursing — The Impossible Dream of Impending Destiny, involved different aspects of nursing — clinical practice, teaching, and research.

Lysaught stressed the importance of a unified effort by nurses to improve their professional status and emphasized the value of research in nursing practice.

Non-health system concerns N.S. nurses

"Restrictive budgeting in health matters has very grave and dangerous overtones," Sister Marie Barbara, president of the Registered Nurses' Association of Nova Scotia, told nurses attending the Association's 67th Annual Meeting held in Halifax.

"There is a national concern for the escalating costs of health care services and nurses share in this concern," she said. "Nurses agree that governments and all those involved in the health care system must take steps to contain expenditures. However, representatives of your association, while accepting the role of responsible leadership and cooperation in continuing expenditures, must speak out forcefully when budget cuts result in deterioration of essential health care services."

Sister Barbara suggested that if hospital services must suffer cutbacks in acute care areas "perhaps we may be more successful in convincing governments that they can provide less costly alternatives to acute care. We have been called to account in the past and can expect that our accountability will increase as the public and public officials become more and more disenchanted with the present cumbersome unproductive 'non-health' system."

"How will the decision to effect cutbacks in student enrollment in 1976 be judged when and if another nurse shortage is provoked several years hence? Who will be held accountable?" she asked.

"It is appreciated that these are frustrating and distressing times for administrative personnel in hospitals and schools of nursing who must continue to meet the public's level of expectation for services on limited budgets. But the RNANS views with concern what it considers precipitate action that may only assure short-term goals. The association rightly feels that it should have a more equal share in health care decisions that may affect nurse manpower supply and subsequent health care of citizens."



The 22nd of June, 1976 was a significant day in the history of the Canadian Nurses Association and its newest member, the Northwest Territories Registered Nurses Association. The date marked the official admission of the NWTRNA into the national association, and participants at the 1976 convention in Halifax witnessed an impressive ceremony to commemorate the occasion. Slides showing the vast expanses of the northern frontier and some nurses at work gave the audience a glimpse into the lives of their northern colleagues. The crowd responded enthusiastically and welcomed the 10 representatives from NWTRNA with a standing ovation.

Huguette Labelle, outgoing president of CNA, presented founding president, Leone Trotter, with a gavel as a symbol of the new member's official admission into CNA. After a short speech, Trotter passed the gavel on to the association's new president, Barbara Bromley, who read congratulatory messages from the Commissioner of the Northwest Territories and from other associations, and briefly outlined the goals of the NWTRNA. As a special tribute to the new member associaton, Louise Miner, past president of the CNA, closed the ceremony by leading the audience in the singing of the Northwest Territories theme song, "North of 60".

The official admission of the NWTRNA into the national association marks the culmination of a long effort to achieve recognition, which began in 1956 when the first meeting of a group of nurses took place in Yellowknife. Recognition of the group as a full-fledged association was achieved in January, 1975.

The 10 NWTRNA members who came to Halifax despite the unpredictability of air travel, were Loretta Abernathy, Barbara Bromley, Sharon Collins, Ann Hendry, Catherine Keith, Janet Lindquist, Ethel MacPherson, Mary Lou Pilling, Lois Torrance, and Leone Trotter.

Mrs. Gladys Smith, director of nursing at the Glace Bay General Hospital is the new president of the association. Other officers are: Marilyn Riley, Halifax, 1st vice-president; Patricia Fraser, Waterville, 2nd vice-president; Jean Dobson, Kentville, 3rd vice-president; Margaret Power, Halifax, Recording Secretary; Jane Buckley, Halifax, Chairman, Nursing Service; Ellen Murphy, Antigonish, Chairman, Nursing Education; Leota Daniels, Windsor, Chairman, Social and Economic Welfare.

Membership in the RNANS now stands at approximately 6,000 registered nurses.

Did you know?

Travelling down south this year? The Canadian Public Health Association has published a small booklet describing what a person going to warm climates should do before he leaves and what immunizations are required. Write to: Canadian Public Health Assoc., 55 Parkdale Ave., Ottawa, Ont. K1Y 1E5.

News

CHA 9th Annual Convention

The high cost of health care was the theme of the Canadian Hospital Association's 9th national convention held at the Chateau Laurier in Ottawa in June.

The keynote address, by Maxwell Henderson, former Auditor General of Canada, set the tone for the three day convention. Henderson told hospital officials attending the the conference that the government's role in health care should be cut back to deal only with capital funding on hospitals and equipment, leaving the major responsibilities for health care to hospital administrators and patients.

Henderson outlined the growth of government health care expenditures in Ontario over the past ten years and said that the public now expects the government to bear the responsibility for maintenance of health services. He said that patients "should pay for the services they need according to their ability with the government picking up the tab for the indigent. If they cannot pay entirely, then they should be assisted through either a means test or income tax credit."

The conference involved many speakers, with many alternate solutions to the present costly health care system. Many of these speakers spoke in favor of decentralization and the return of responsibility for health care to individual administrators, health care personnel, and patients or 'clients.'

Jean Lupien, Deputy Minister of Health, suggested that health care dollars be diverted from hospitals to related services and preventative medicine.

Seminar in Occupational Health

Close to 40 nurses, the majority from Nova Scotia, but some from New Brunswick and one from Labrador, attended the Spring Seminar for Occupational Health Nurses in Halifax. Sponsored by the Registered Nurses' Association of Nova Scotia, the seminar was planned to help nurses who are carrying out health programs in industry or hospitals, to bring them up-to-date on particular aspects of their work, and to give them an opportunity to share experiences and knowledge.

Some program highlights of the two-day seminar were: "The Cardiac at Work," Dr. C.R. May, Director, Occupational Health, Dept. of Public Health; "Safety," J. D. Fleming, Chairman, N.S. Chapter, Canadian Society of Safety Engineers; "Emergency Treatment of Burns," and "Industrial Dermatitis," Dr. Jennifer Kotz, Consultant in Dermatology, Dalhousie University.

Coordinators of the Planning Committee were Margaret Grice, Nurse-in-Charge, Public Health Unit, Health and Welfare Canada, Halifax, and Brenda Penny, Supervisor, Health Services Branch, Cape Breton Development Corporation.

Good Samaritan Law in Effect in Saskatchewan

Those practising emergency aid at the scene of an accident are now protected from liability by law in the province of Saskatchewan. An Act Respecting Emergency Aid became law in Saskatchewan on May 7, 1976.

Section 3 of the Act states "Where, in respect of a person who is ill, injured or unconscious as a result of an accident or other emergency:
a) a physician or registered nurse voluntarily renders emergency medical services or first-aid assistance and the services or assistance are not rendered at a hospital or other place having adequate medical facilities and equipment; or
b) a person other than a person mentioned in clause (a) voluntarily renders emergency first-aid assistance and that assistance is rendered at the immediate scene of the accident or emergency;
the physician, registered nurse or other person is not liable for damages for injuries to or the death of that person alleged to have been caused by an act or omission on the part of the physician, registered nurse or other person rendering the medical services or first-aid assistance, unless it is established that the injuries or death were caused by gross negligence on his part."

American Lung Assoc. Nursing Fellowship

Nursing fellowships for graduate study in respiratory disease are being offered by the American Lung Assocation.

Training fellowships directed towards a career as clinical specialist, teacher, or researcher in the care of patients with respiratory conditions are offered to graduates of accredited baccalaureate schools of nursing.

The fellowships are in the amount of $6,000 per year with the possibility of one renewal for a maximum of two years of support.

Awards are limited to U.S. and Canadian citizens or holders of bona-fide permanent visas for study in U.S. institutions. Completed applications must be received by March 15, 1977.

Awards are also being offered to University Programs in Nursing for the development of Respiratory Clinical Nurse Specialty Programs leading to a Master's degree.

The objective of the program is to prepare professional nurses to assume leadership roles in the care of individuals with lung disease and also to prepare academic specialists.

The awards are in the amount of $25,000 per year with the possibility of renewal for a maximum of three years of support. Completed application must be received by November 1, 1976. Address inquiries to: *Marilyn Hansen, Consultant in Nursing, American Lung Association, 1740 Broadway, New York, N.Y. 10019.*

RNANS meets with Health Minister

Minister of Health, Allan Sullivan, and the Deputy Minister, Dr. Peter Nichols, recently met with Gladys Smith, President of the Registered Nurses' Association of Nova Scotia, and other members of the Association to discuss mutual problems with particular reference to the current restraint program.

Concern was expressed by the nurses that without long-range planning, and with few alternatives to acute care, the restraints may cause increased difficulties for people to secure health care when needed. They felt too, that an additional backlog of elective treatments may, in the long term, result in costly crises. Among other topics discussed were: basic nursing education, in-service development, health education in schools and regulations for nursing homes.

Smith pointed out that nurses are in a unique position to influence life styles and promote health. She expressed the need for nurses to be active participants in planning for health care and in solving current problems related to nursing practice.

To facilitate communications between the Ministry and the Nursing Association, a Nursing Advisory Committee will be established to meet with the Minister and the Deputy Minister on a regular basis.

Did you know?

In 1973 in Northern Ireland, an Integrated Health System was established which took responsibility for the totality of Health and Social Services in Ulster.

The main government department is divided into four Boards that establish policy. Each Board is subdivided into districts. Each district board consists of a multidisciplinary team — a doctor, nurse, social worker, chairman of the Medical Advisory Board, and administrator — who function equally within the team and whose task it is to administrate and coordinate all health services in their district.

Kathleen Robb, District Administrative Nursing Officer for North and West Belfast, visited CNA House recently. She explained that her district looks after the total health needs of the population — not an easy task since her district includes the war torn areas of Belfast. Emergency care, general hospital care, community care, social service etc. are all within the boundaries of the team. This means that expertise from all areas of health and social welfare can be utilized for the better application of facilities and personnel. She stressed the nurse's role in this team as being equal in importance to that of all the other team members.

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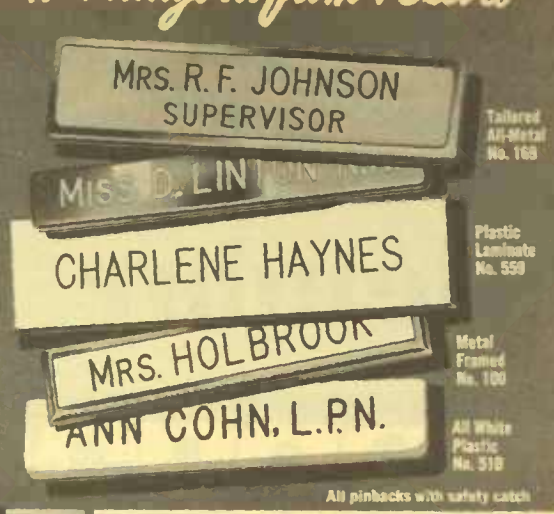
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					2 Lines Lettering . .	☐ 3.49	☐ 5.79
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100	**METAL FRAMED** . . . Smooth plastic background with classic, distinctive polished metal frame. Beveled and rounded edges and corners. Smart professional appearance.	Frame: ☐ Gold ☐ Silver	☐ White ☐ Green ☐ Blue ☐ Brown →	☐ Black ☐ Dk. Blue ☐ White			
559	**PLASTIC LAMINATE** . . . Slim, broad, yet lightweight. Engraved through surface into contrasting core color. Beveled border matches lettering. Excellent value.	☐ White ☐ Med. Green ☐ Med. Blue ☐ Cocoa →		☐ Black ☐ Dk. Blue ☐ White	1 Line Lettering . .	☐ 1.49	☐ 2.49
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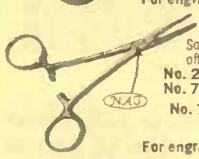
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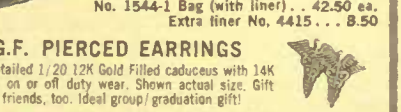


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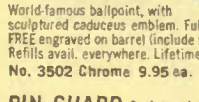


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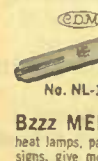


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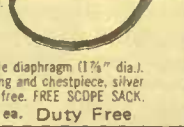
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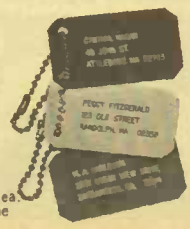


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Calendar

August

Ninth International Conference on Health Education will be held at the Skyline Hotel, Ottawa, Ontario, Aug. 29 - Sept. 3. Theme: "Health Education and Health Policy in the Dynamics of Development." For information, write: *Canada's Organizing Committee, Ninth International Conference on Health Education, c/o CHESS P.O. Box 2305, Station D., Ottawa, Ontario, K1P 5K0.*

Critical Care Nursing: an eight-week program offered five times a year, to those registered or eligible for registration in the Province of Nova Scotia. The next program begins Dec. 6, 1976 with an application deadline of August 30, 1976. For further information, contact: *Group Leader, Critical Care Program, Continuing Education, Victoria General Hospital, Halifax, Nova Scotia, B3H 2Y9.*

September

Respiratory Week — 1976 Educational Forum, at the Calgary Inn Hotel, Calgary, Alberta, Sept. 1 - 3, 1976. Contact: *Ms. E. Lord, Registration Chairman, 6528 — 23 Ave. N.E., Calgary, Alberta, T1Y 1V4.*

Annual Conference: Emergency Nurses Association of Ontario to be held at the Royal York Hotel, Toronto from September 8 - 10, 1976. Contact: *Mrs. Mary Arntfield, 897 Baltimore Ave., Mississauga, Ont., L5J 2R4.*

Annual Meeting of the Atlantic Provinces Psychiatric Assocation to be held in Saint John, New Brunswick on Sept. 16 - 18, 1976. For information contact: *J.D. McLean, M.D., 66 Waterloo St., Saint John, New Brunswick.*

"Nursing and the Law" with Lorne Rozovsky at McMaster University Centre, Hamilton, Ontario on September 18, 1976. For information, contact: *Miss D. McClure, Educational Co-ordinator, Hamilton General Hospital, Barton St E., Hamilton, Ontario L8L 2X2.*

RNAO — 20th Annual Conference at Honey Harbour, Georgian Bay, Ontario. Four unique programs: Sept. 20 - 24, 1976, You as a Person; You as a Team Leader; You as a Manager of Change. Sept. 18 - 25, 1976, Advanced Program in Group Leadership. Contact: *Professional Development Department, RNAO, 33 Price St., Toronto, Ontario, M4W 1Z2.*

The Present Status and Future Directions of Residential Treatment for Disturbed Children to be held at the Chelsea Inn, Toronto on Sept. 22-24, 1976. The Symposium will feature talks and workshops conducted by experts in the field of children's mental health. For further information contact: *Dr. Philip Baker, Thistletown Regional Centre, 11 Carr Ave., Rexdale, Ontario, M9V 2A3.*

The Computer and the Nurse, to be held at Mountain View, California, on September 23 - 25, fee $135.00. Contact: *Institute of Nursing Consultants, Fay Bower, 874 Miranda Green, Palo Alto, California 94306.*

Creating A Climate For Care — Role of the Director of Nursing Service at the Statler Hilton Hotel, 16th and K Streets, N., W., Washington, D.C. 20036, September 24 - 25. Contact: *CONVENTION SERVICES, National League for Nursing, 10 Columbus Circle, New York, New York, 10019.*

Association of Registered Nurses of Newfoundland — 22nd Annual Meeting to be held at the Holiday Inn, St. John's, Sept. 27 - 29, 1976. For further information, write: *ARNN, 67 LeMarchant Road, St. John's, Newfoundland.*

"Recent Advances in Respirology for Family Physicians" at McMaster University Medical Centre, Hamilton, Ontario on September 29, 1976. For information contact: *Dr. N.L. Jones, Professor, Department of Medicine, McMaster University Medical Centre, 1200 Main Street West, Hamilton, Ontario L8S 4J9.*

October

Association of Canadian Medical Colleges — Annual Meeting to be held at the Bayshore Inn, Vancouver, B.C., Oct. 3 - 5, 1976. The Association of University Schools of Nursing, and of Rehabilitation, are two associations holding meetings in conjunction with ACMC. Information: *Mr. C.A. Casterton, Executive Secretary, Association of Canadian Medical Colleges, 151 Slater Street, Ottawa, Canada, K1P 5H3.*

Canada Safety Council — 8th Annual Conference to be held at the Skyline Hotel — Holiday Inn, Ottawa, Ontario from Oct. 3 - 6, 1976. Topics to be discussed include: Occupational Safety, Public Safety and Traffic Safety. For information contact: *Conference Department, Canada Safety Council, 1765 St. Laurent Blvd., Ottawa, Ont. K1G 3V4.*

The Professionals and Public Policy. A national conference sponsored by the Law and Economic Program, Faculty of Law, University of Toronto. Guest Speaker: Dr. Ivan Illich. Includes plenary and workshop sessions. To be held at the Ontario Institute for Studies in Education, Toronto on Oct. 15 - 16, 1976. Registration fee: $120.00. For further information, contact: *Conference on the Professions and Public Policy, Conference Office 12th Floor, OISE, 252 Bloor St. W., Toronto, Ontario, M5S 1V6.*

Assertiveness Training Workshop to be conducted by H. Fensterheim and J. Baer, authors of "Don't Say Yes When You Want to Say No" and G.V. Kroetsch and G.D. Pulvermacher. To be held at the Hotel Bonaventure, Montreal, Quebec on Oct. 16 - 17, 1976. For information write: *Centre for Behaviour Therapy and Assessment, 3029 Carling Avenue, Ste. PH-2, Ottawa, Ontario K2B 8E8.*

Five Year Reunion - Lethbridge Community College R.N. Graduates. To be held on Oct. 23 - 24, 1976. Contact: *Joy Stenbeck, 434 - 12 Ave. North, Lethbridge, Alta., T1H 1P3.*

Fifth Annual Pediatric Refresher Course for Primary Care Physicians to be held at McMaster University Medical Centre, Hamilton, Ontario on Oct. 29 - 30, 1976. For information contact: *Dr Ross Parker, Associate Professor, Department of Family Medicine and Pediatrics, McMaster University Medical Centre, 1200 Main St. West, Hamilton, Ontario, L8S 4J9.*

November

Every Physician A Geneticist. A two-day course on the practical approach to the recognition and management of genetic problems seen in the physician's office. Sponsored by the Post Graduate Board for Continuing Medical Education of McGill University and The Montreal Children's Hospital. Approved for credits. Nurse-practitioners are welcome to register. To be held at Le Quatre Saisons, Montreal on Nov. 4 - 5, 1976. Fee: $125.00. For information contact: *Dr. H. Goldman, Post-Graduate Board, Montreal Children's Hospital, 2300 Tupper St., Montreal, Quebec.*

Health Care Delivery Systems in North America: The Changing Concepts 18th Canadian-American Seminar to be held at the University of Windsor, Windsor, Ontario on Nov. 11 - 12, 1976. For details write: *J. Alex Murray, Director Canadian-American Seminar, University of Windsor, Windsor, Ontario, Canada N9B 3P4.*

Clinical Application of Intra-Aortic Balloon Pump (IABP) (Second Annual Postgraduate Course) at the University of Miami School of Medicine, Miami, Florida on Nov. 12 - 13, 1976. Sponsored by the Division of Thoracic and Cardiovascular Surgery and Cardiology, Department of Medicine, in cooperation with the Heart Association of Greater Miami. AMA accredited. Information: *Division of Continuing Medical Education, University of Miami School of Medicine, P.O. Box 520875, Miami, Florida 33152.*

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Photos by Suzanne Emond, R.N.

The week of June 14, was declared demonstration week by the Public Health Nurses of Ontario. During that week, 350 nurses, employed by 26 health boards, assembled in front of the Parliament Buildings in Toronto to urge elected representatives of the public and government to take action to provide compulsory arbitration for the orderly resolution of unresolved contract items. Since 1965, nurses in Public Health Units have had to resort to strike action four times in an attempt to resolve their contract disputes.

Their message is that they are fed up with strikes, with lockouts by their health unit, fed up with leaving patients. The Public Health Nurses want the same rights as other nurses in the province who are classified as essential workers and as such are prohibited from strike action.

Anne Gribben, executive director of ONA, who met with Labor Minister Dr. Bette Stephenson and Health Minister Frank Miller, told the nurses that neither minister would answer the nurses' demands for arbitration.

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Annual Meeting and Convention, Canadian Nurses' Association June 20 - 23 1976, Hotel Nova Scotian, Halifax

The skirl of pipes and the laughter of nurses from all across Canada, as they reminisced with one of Canada's best known story tellers, set the tone for the opening ceremonies of CNA's annual meeting and convention in Halifax this year.

W.O. Mitchell, author of "Who Has Seen The Wind" and the Jake and Kid radio series, carried his happy audience back into Prairie childhood days as he recalled that "trail-blazer in the field of mental health, Melvin Arbuckle", and the "first known use of shock therapy."

Newfoundland president, Roberta Clegg, who introduced the speaker, thanked him for his contribution to the convention of "some of the best medicine in the world — laughter".

Delegates received official greetings from the Prime Minister of Canada. Telegrams were also received from officials of the Pan American Health Organization/World Health Organization and the executive director of the American Nurses' Association, Eileen Jacobi on behalf of the ANA president and board of directors. Nova Scotia Premier Gerald A. Regan, who brought greetings from the provincial government, reminded delegates that the right to adequate health care, regardless of financial means, is an important and often overlooked part of the quality of Canadian life. He pointed out that free drugs for senior citizens and financial aid for students are two of the factors that play an important part in determining the quality of life for many people.

CNA delegates were officially welcomed to the city of Halifax by Mayor Edmund Morris and the deputy mayor of Dartmouth, L.M. Fredericks. Second vice-president of the International Council of Nurses, Margaret Scott-Wright, extended an invitation to Canadian nurses to attend the International Congress in Tokyo next spring and told them that Canada now represents one of the largest groups belonging to the ICN. Dr. Scott-Wright, who was the first person to be appointed professor of nursing studies in the United Kingdom, has carried out several temporary assignments for WHO and recently accepted the position of director of the school of nursing at Dalhousie University in Halifax.

Several associations and special interest groups in the health field sent official representatives to the opening ceremonies of the CNA meeting. These included: the Canadian Hospital Association, Canadian Medical Association, Canadian Council on Hospital Accreditation, Department of the Secretary of State, Psychiatric Nurses Association of Canada, Canadian Division of the International Association of Enterostomal Therapists, Canadian Association of Practical and Nursing Assistants, Canadian Dental Association, Canadian Pharmaceutical Association, Canadian Association of Neurological and Neurosurgical Nurses, and the Canadian University Nursing Students' Association. The recently elected president of the Nova Scotia Nurses Association Gladys Smith, welcomed CNA members on behalf of the RNANS.

During an interview following the opening ceremonies, Watson commented that the Canadian Nurses Association, because of the numerical strength of its membership and the fact that its members represent "the cream of the educational crop," is potentially a very significant organization. "If they can get it all together," the broadcaster commented, "nurses can make things happen for them. Potentially, they represent a mighty force in the field of health care."



Patrick Watson



"Every human being is the repository of an enormous bank of knowledge and experience — the only problem lies in finding out how to get in touch with this experience," according to Patrick Watson, well known Canadian public affairs broadcaster. He believes that in our culture, there is too much emphasis placed on certification of educational qualifications and too little recognition of the importance of the spontaneous capacity for individual examination of actual experience. He urged his audience of close to 1,000 nurses attending the first session of the CNA convention to use this knowledge and experience with confidence to serve the cause of humanity. "Whether you like it or not," he said, "as professionals, you are exemplars and therefore influential in your community."

Watson's address set the tone for the three days of events that followed. He substituted as keynote speaker when Ralph Nader, originally scheduled to speak on the "Quality of Life," was not able to get to Halifax because of the airline strike.

Watson reminded the nurses that their concern for the quality of life must go beyond hospital wards and clinics. "As soon as you begin to engage in one social problem, if you are true to your spirit, you end up by being engaged until time and spirit run out. You cannot stop with the quality of life in the medical environment. You have to be involved with your community, town, city, country, the whole world." He described Canada as having a strong tradition of relying on certificates awarded at the completion of training "to show you can do the job" and suggested that nurses should not rely on this criteria in the evaluation of members of their profession. "The only way to assess a person's true value, is through human contact," he said.

Watson suggested that "the single most important advance in medicine in recent years has not been in the field of technology but rather in the slow, not dramatic, transformation of the role of the doctor in relation to his patients from a God-like authority to a human being. We created the seductive myth of the infallibility of the physician," he said, "and until recently, doctors have not tried to change it."

Senator predicts new direction for nursing

"The future of nursing appears to lie more in the community and less in the hospitals than has been the case in the past." This was the message delivered by Senator Alasdair Graham on behalf of the Hon. Marc Lalonde to CNA delegates on the second morning of the annual meeting. Senator Graham delivered the address for the Minister of Health and Welfare who remained in Ottawa to vote on the question of abolition of the death penalty in Canada. "Nurses can exploit the time that a person is in hospital, to teach that person about healthy lifestyles, but in the future their work will probably lie more extensively in the community," Senator Graham said. He urged nurses to consider the alternatives of going into the home, schools and industry in order to improve the quality of life and affect the behavior of individuals before it becomes detrimental to life and health. "Above all," he said, "you must be where the people are."

The senator pointed out that occupational health has been identified as a priority area by the latest Federal-Provincial Conference of Health Ministers and said that preventive measures are being stressed. "There is obviously great need for safety surveillance and education, industrial hygiene surveillance, improved first aid programs and good occupational health services — all areas where nurses can be involved." He predicted that nurses would also encounter increasing opportunities to care for the growing number of elderly in the population, many of whom could be moved to more appropriate and less costly nursing homes. "At no other time has it been so important to look at alternative forms of health care," he stated. "The country cannot afford for very much longer the type of rise in health costs that has been experienced in recent years. It has been shown that pouring more money into health care does not necessarily translate into better health. In other words, the quality of life is the critical factor in health and in the avoidance of unnecessary illness and premature death."

The senator called on nurses to take a

A highlight of the final day of the convention was a round table discussion on the quality of life in the work world of the nurse. Participants were: Ginette Rodger, director of nursing service and education at Notre Dame Hospital in Montreal; André Payeur, Montreal lawyer; Mary Vachon, mental health consultant at the Clarke Institute of Psychiatry; and Anne Gribben, chief executive officer of the Ontario Nurses' Association.

Due to the air strike, Anne Gribben was not able to participate in the discussion but her paper on the socio-economic pressures on the nurse was presented by Linda Gosselin, also of ONA. Ginette Rodger dealt with the difficulties a new graduate faces when she first enters the work force. The present and future possibilities for legal protection of the nurse were discussed by André Payeur. Mary Vachon presented a paper on the "Enforced Proximity to Stress in the Client Environment," reprinted next month in *The Canadian Nurse*.



Some members of the round table discussion, pictured above, are (left to right). Ginette Rodger (speaking); Jeannine Tellier-Cormier (moderator); Mary Vachon; and Linda Gosselin.

On the opposite page, Patrick Watson talks to (from left to right) Ruth May, Shirley Post, Cathlyn Macaulay and Pamela Poole.

▶ more active and influential role in the decision-making process. "Possibly, in the past, you were content to minister in the sick rooms of the nation and did not make much effort to seize the initiative, but this situation is changing very rapidly. The nurse's role has been expanding with the acceptance of new goals for women and, on the other hand, an increasing number of men are entering the nursing profession, as sex-typing of career roles diminishes. Now is the time for the nursing profession to consider taking on a broader orientation. It is time there were more nurses on the boards of hospitals, and more than that, the boards of universities, and industries."

Nurses debate preservation of life

The dilemma concerning the quality of life in its final stages and the preservation of life at all costs is central to the professional philosophy of all nurses. Each nurse must decide for herself the nature of the care and support she can offer the dying patient. Some of the considerations that may enter into this private decision were formally aired during the CNA annual meeting by four nurses who took part in a public debate on the subject.

The resolution presented for discussion was: "Resolved that nurses have responsibility to take a stand to preserve life in the event of any decision by a patient, a family or a professional to discontinue life-sustaining intervention." Two speakers — Brenda Allt, RNANS, and Sheila O'Neill, ONQ, represented the affirmative side of the debate. Members of the opposing team were Margaret McLean, ARNN, and Suzanne Brazeau, RNAO. Apolline Robichaud, past-president of the New Brunswick Association of Registered Nurses, chaired the debate. She reminded the audience that the beliefs and actions of nurses regarding the preservation of life are subject to increasing pressure and controversy because of the pace of current technological developments. Within the time limits set by the chairman, the participants raised a series of considerations both in favor and against the resolution. Among the points they discussed were:

- the factors that enter into the patient's ability to give informed consent based on reason, argument and belief;
- the inability of professionals to measure death and the need to define it in terms of the current state of knowledge;
- the pressures placed on the family of a dying patient during a crisis situation and how this affects their decision-making process;
- the fact that individual nurses must lose their own fear of death in order to offer adequate support to patients who are dying;
- the belief that an important aspect of the nursing process is the ability to offer the patient the care and support that enables him to have the kind of death he needs or wants.

The quality of life, a personal approach to some important problems

One of the highlights of the '76 CNA convention was an interview by Patrick Watson with four nurses who *are* making significant and unique contributions to the quality of life for Canadians. New approaches to palliative care, maternity and child care, nursing research, and the personal responsibility of each individual to seek solutions to problems around him, were discussed by Cathlyn Macaulay, Ruth May, Pamela Poole and Shirley Post. The accounts of their experiences and their answers to Watson's probing questions raised some of the basic issues that nursing leaders are now faced with and prompted a discussion that continued for an hour after the interview was scheduled to end.

Cathlyn Macaulay described a team approach to nursing dying patients where the *patient* is leader of the team and the nurse works with the patient and his family as "unique individuals with unique needs, including pain and symptom control and the resolution of emotional, interpersonal, spiritual and financial difficulties." Macaulay is head nurse of the Palliative Care Domiciliary Service, Royal Victoria Hospital, Montreal. The unit opened in January 1975 as a two-year pilot project.

The nurses in the unit are specialists in the control of intractable pain; under a doctor's order they have the freedom to administer analgesics, in the form of Brompton's cocktail,

in the strength necessary so that dying patients can maintain their capacity for enjoying life until the actual physical moment of death. The nurses are supported by three "fine" doctors who will make home visits when asked to do so.

Macaulay stressed that the quality of life of patients, what is important to them, "may be completely different from yours." But it is the preservation of the patient's unique enjoyment in life that is the goal of her unit. "Attention to detail is what is important to people who are dying," she said. She recalled a lady "who was nearly blind, very ill with cancer. She lived in a room in a boarding house, an atrocious situation really. But for her, to stay there, at home, was the most important thing in her life. We managed to keep her at home with her own medications, using enormous signs so she would take them at the proper time."

In treating the patient and his family as a unit, the nurse must work in many dimensions, practicing psychology, giving spiritual help, and offering practical financial advice. As well as helping the family come to terms with the fact that their loved one is dying, the nurse may be called on to help with funeral arrangements, to get in touch with clergy, or to say a prayer at the end.

The nurse who works with dying patients must come to terms with her own feelings about death and suffering, but Macaulay says the rewards are great. When asked how her work affects her personal life, she answered, "I have learned a great deal as a person... I am much more aware how precious life really is... I enjoy my life all the time. You become very aware of everything that, within yourself, is important in your own life."

Ruth May, assistant professor and lecturer in outpost nursing at Dalhousie University, dealt with the other end of the birth-death spectrum when she talked about the role of the nurse-midwife in the maternity process.

Canada is one of a very few countries that do not use midwives as a normal part of maternity care, she said. Yet a study of perinatal mortality figures indicates that we do not compare well with countries such as Sweden, Denmark, Norway, Britain and the Netherlands, where midwives are used as the backbone of maternity care. She cited a study in rural Mississippi, where the introduction of nurse-midwives in the '70s reduced mortality rates to below the national average, as proof that the use of a nurse-midwife can reverse this trend.

She stressed that there is an important and unique role for the nurse-midwife in Canada to provide comprehensive care for mother and baby throughout a normal pregnancy. "Canadian women everywhere are looking for the kind of counselling they can get beyond the physician's office," the care that physicians, who are busy looking after the complications of pregnancy, haven't the time to give.

But concrete research is needed to answer a number of questions. Is there a need for the nurse-midwife in urban as well as in rural areas? What are the implications for the medical profession? "What we need is demonstration projects, adequately funded, so that there is a sound basis for research about the role of the midwife in Canada," she said. One such project was carried out by a group of Winnipeg physicians in 1971. The group hired a nurse-midwife as a full associate in practice and paid her a salary to provide counselling for patients with routine pregnancies. Although the service did not enlarge their practice, patients were enthusiastic and felt they received better care.

A question by Patrick Watson about the obstacles to the acceptance of nurse-midwives in maternity practice drew spirited comment from the audience. It was pointed out that many OB/GYN specialists are hesitant to accept the nurse-midwife as an associate because it may mean a threat to their practice. At present, there is no provision for payment of the nurse-midwife except through the specialist's earnings, and it is unlikely that the practice will be enlarged as a result of this addition. May stressed that, although support for the nurse-midwife is increasing, the primary obstacle is financial due to our system of health care payments.

What can one person do to better the quality of life? **Shirley Post,** a health care consultant from Ottawa and former Director of Nursing at the Children's Hospital of Eastern Ontario, believes that every individual has a personal responsibility to improve the quality of life for all. She stressed that nurses need more self-confidence to fight for the things they believe in, and that the best place to start making a contribution is "wherever you're at ... Every public reform began as a private opinion." Nurses are in a good position to see possibilities for improvements in areas such as nutrition, immunization and community health care, and to become instrumental in getting these improvements implemented.

Her own experience of "fighting city hall" began when she moved to a subdivision and organized a petition for more and better sidewalk facilities. Her success convinced her that one person can make a difference, and she started to agitate for better quality health care services for children in the community. This involvement blossomed into a large and powerful movement and seven years later the Children's Hospital of Eastern Ontario opened in Ottawa.

Comments from the audience focused on the idea that nurses must first like themselves and have the strength of their convictions in order to pursue their goals in the face of opposition. The rewards of taking risks and fighting for a better life were summed up by Patrick Watson as the satisfaction of "personal, spiritual survival."

In some cases, however, it is not lack of commitment but lack of know-how in procuring the necessary funding that stops many worthwhile projects in the planning stages. **Pamela Poole,** Chief of the Information and Evaluation Division of the Research Programs Directorate at Health and Welfare Canada, outlined some of the funding mechanisms available through her department that can make it possible for concerned citizens to have an effect on health care.

With federal funding, available from the Research Programs Directorate, it is possible for nurses, even if they are not experts at research, to create experimental models in such areas as health care distribution and health promotion. She described a few of the projects the Directorate has been involved in, including one in B.C. launched by a group of women who were concerned about the lack of sensitivity on the part of doctors to distinctly female health problems. With the assistance of the program, the group, which is led by a nurse, set up the Vancouver Women's Health Collective, a cancer prevention clinic designed to teach women to examine their own breasts and do their own Pap smears.

Patrick Watson, committed in his own way to communications, stressed the importance of sharing new ideas and experiences to stimulate change and improve the quality of life at all levels.







A taste of down East hospitality

"One song leads on to another,
One friend to another friend ..."

While participants at the 1976 CNA Convention in Halifax spent a good part of the three days in serious discussion and business, a group of nurses from the RNANS were busy behind the scenes making sure that not all *the time was spent working.*

Opening night entertainment included a musical welcome from the Dartmouth Junior Pipe Band, the Halifax City School's Ukelele Band, the Acadian Chorale and a hijacking by the Jolly Tars, ending the evening with a Welcome to Nova Scotia Punch Party. For those who may have been inclined to sleep in after Sunday night's punch party, Monday morning's session was opened by Nova Scotia nurses dressed in Sou' Westers singing a rousing chorus of "Black Rum and Blueberry Pie."

To give visitors a preview of the cultural attractions in Nova Scotia, an artistic representation of the quality of life theme, presented Wednesday morning, featured actors Joan Orenstein and David Renton from Halifax's famed Neptune Theatre, Acadian singer Marie-Paule Martin and pianist John Robie.

Monday and Tuesday nights, association members had an opportunity to relax at their choice of three functions. A tour to Peggy's Cove ended with a lobster dinner (two lobsters each!!) and dancing at the Legion Hall in the seaside village of Prospect. A water tour of the Halifax harbour featured a shore dinner at the Clipper Cay restaurant on historic Privateer's Wharf. Or, for those who preferred the charm of the old country, a Scottish Ceilidh and buffet dinner was held at the Chateau Halifax. At all three events song sheets were provided, and warmth, laughter and song brought friends and colleagues from all parts of the country together.

By the end of the three-day convention guests had, indeed, experienced a taste of "down East hospitality." Some were so won over that, when homeward flights were cancelled, they simply relaxed and made plans to visit more of the province. If you have to be stranded somewhere, what better place than Nova Scotia?





Members of CNA's new Executive Committee for the next two years, elected by voting delegates during the 1976 meeting in Halifax, are: (left to right) Barbara Racine, Shirley Stinson, Joan Gilchrist (seated), Sheila O'Neill, Helen Glass, Linda Gosselin, Lorine Besel and Helen Taylor

Introducing . . . your new executive



Canada's national nursing organization enters the 1976-1978 biennium with a strong vote of confidence from nurses across the country, the promise of increased financial support from its eleven member associations, and a newly elected executive determined to bring the causes and concerns of the nursing profession before a national forum and to try to find effective solutions to contemporary problems.

The president for the coming biennium, **Joan M. Gilchrist,** receiving the chain of office from outgoing president, Huguette Labelle, expressed it this way: "The potential magnitude of the responsibility of this office and the isolation of the presidency can only be redeemed by the commitment of CNA directors elected today. It is with the conviction that concerted and effective action is possible that I accept this presidency." Professor and director of the McGill University School of Nursing, Gilchrist headed the slate of CNA officers elected during the association's recent meeting. In her acceptance speech she paid tribute to the personal and professional qualities of former president, Huguette Labelle, and touched on some of the key issues for the next biennium. She spoke of the critical need for large associations to make their position on important issues known to the public so that they do not destroy their credibility. "At the same time, we must find ways to handle the input of our enormous membership so that the organization does not, if it has not already done so, deprive our members of direct contact with their elected representatives."

The new president, was formerly director of nursing and principal of the School of Nursing at the Jewish General Hospital, Montreal, and supervisor of Mount Sinai Hospital, Toronto. She is currently working on her Ph.D. in Sociology.

Gilchrist is chairman of the Canadian Association of University Schools of Nursing Committee on Structure and also a member of the Council of Deans and Directors. She is a member of the Special Committee on Nursing Research of the Canadian Nurses Association and, for the past two years has been president-elect of the CNA.

Other officers elected for coming biennium are: president-elect — **Helen Taylor,** director of nursing, Montreal General Hospital, Montreal and vice-chairman of the Board of Directors of the Canadian Council on Hospital Accreditation; first vice-president —**Shirley Stinson,** professor, School of Nursing, and Division of Health Services Administration and graduate program coordinator, University of Alberta;
second vice-president —**Sheila O'Neill,** nursing director, Medical Pavilion, Royal Victoria Hospital, Montreal;
— **Barbara Racine,** assistant executive director, Nursing Practice, Royal Columbia Hospital, New Westminster, B.C.;
member-at-large for nursing administration;
— **Helen Glass,** director, School of Nursing, University of Manitoba, member-at-large for nursing education;
— **Lorine Besel,** director of nursing, Royal Victoria Hospital, and assistant professor, McGill University School of Nursing, Montreal;
member-at-large for nursing practice;
— **Linda Gosselin,** employment relations officer, Ontario Nurses Association, Toronto, member-at-large for social and economic welfare.



A retrospective assessment

CNA's retiring president, Huguette Labelle, in her address to delegates on the second day of the annual meeting, issued a strong plea to nurses not to lose sight of the "fundamental element of nursing — the care and support the profession provides for the people it serves" in the midst of their concern over expanding into new roles in the years ahead.

She expressed concern over the "trade-off" that occurs when functions formerly assumed by members of the medical profession are transferred to nursing and warned of the danger of losing sight of the fundamental care and support activities that are the basis of the nursing process.

"More than ever, we must live up to the statement that nursing is the 'conscience' of the health care system," she said. "Our 'conscience' demands a strengthening of our caring role that continues to lead us towards the elusive grail of quality care."

In her review of activities during the biennium when she provided leadership for the national association, Labelle described some of the changes that have taken place and attempted to identify changing needs and trends for the months ahead. Among the contemporary concerns she identified were precarious employment situations for both new and experienced nurses, the need to develop alternative health services and to prepare nurses to fill these roles in the community. She stressed that nurses must become more directly involved in the planning and development of health care policy and services so that they are in a position to act rather than react and warned that, "unless we develop better mechanisms for forecasting nursing manpower requirements more accurately, there could be another 'shortage' within a few years if natural attrition is not compensated by a new supply of nurses."

"For those who are unable to obtain work, it is certainly an anxious time and as a responsible professional association we must be actively concerned. We need to study ways of reducing the impact of unemployment and of preventing such occurences in the future. We cannot condemn recruiting of Canadian nurses by other countries since we have done the same in the past but loss of nurses from the current pool combined with decreased enrolment in diploma schools of nursing could make the pendulum swing from shortage to oversupply within a few years."

She called on nurses to take advantage of this period of relatively stable employment pattems to develop better nursing services in acute care settings and to demonstrate that "nursing, *good* nursing, does make a measurable difference in patient care." She stressed also the need to prepare "front-line" nurses to function in altemate settings and predicted that it would be as "health practitioners" that nurses would emerge in important new roles. "We now have an outstanding opportunity to identify alternative services and to determine how and in what situations, nurses can benefit the population. The question we must answer now is how we can increase our impact on the quality of Canadian life."

Labelle, who served on the CNA Board of Directors for six years, was given a standing ovation at the conclusion of her address.



One of the responsibilities accepted by CNA directors is that of "reporting fully to the Association at each annual meeting." In Halifax this June, executive director, Helen K. Mussallem, reported to membership on behalf of the Board of Directors. Highlights from this report are presented here for your information.

A report to membership

Membership
Admission of the Northwest Territories Registered Nurses Association in December, 1975, brought the total number of CNA association members to eleven and the number of directors of the corporation to nineteen. Individual membership in CNA through member associations (not including the NWTRNA) reached a new high of 111,846 in that same month.

Action on Resolutions From 1974 and 1975 Annual Meetings

- Members of the Board of Directors assumed responsibility for reminding their jurisdictions of the importance of submitting resolutions to CNA as early as possible. Resolutions submitted prior to the end of March appeared in the April issue of *The Canadian Nurse* and *L'infirmière canadienne*. Those received by early May were reproduced and distributed with voting delegate kits mailed to all association members one month prior to meeting. Resolutions received after that time, or during the annual meeting, were distributed — in accordance with present procedure — to members attending the annual meeting.

- A Health Promotion Program for Nurses was developed to raise the level of awareness of nurses to lifestyles conducive to optimum health. This program was designed in collaboration with Recreation Canada and the Canadian Public Health Association and received a grant of $18,500 from Recreation Canada.

- The Board of Directors authorized a study to provide a current description of the practice of nurses functioning in the expanded role. Directors believe that a description of practice is required prior to establishing guidelines for preparation, continuing competence to practice, responsibilities, legal protection and remuneration for nurses in an expanded role as requested by membership. This project, named as a priority by the Board of Directors, has received funding from Health and Welfare Canada — Health Research and Development Program Grant.

- The Board of Directors took action to encourage the development of courses in geriatrics and long-term care for registered nurses through discussion and communication with appropriate bodies such as Canadian Association of University Schools of Nursing, Association of Canadian Community Colleges, Canadian Association of Gerontology and member nurses' associations.

- The Association was in communication with the Minister of National Health and Welfare to urge that sufficient qualified staff be engaged to provide, upon request, multidisciplinary consultation services to persons engaged in the development and implementation of Health Research Projects. The Minister has advised that his Department is exploring ways of meeting the need for multidisciplinary consultative service in connection with research services. In addition, Health and Welfare Canada has provided CNA with a roster of present Senior Health Research Scientists and copies are available.

- The *Nursing Studies Index* was published in 1974 and an addendum to the *Index* was published in 1975. The price of the *Index*, which covers cost of printing only, is $5.00 and the addendum $1.00.

- A directive "...that the CNA adopt the practice, to the extent possible, of using given and surname only for all identification purposes" was implemented by Association staff in journals, corporate documents and correspondence.

- A new formula for payment of fees was accepted at the 1975 annual meeting and became effective 1 January 1975.

Projects and programs
Early in this biennium, the President identified four main priority areas. The Directors, their committees and staff collaborated to make significant progress in each area. Some are long-range projects or programs that will continue beyond

this biennium; some were begun prior to this two-year period. The major ones are:

- *National Survey of Nurses*

A national postal survey of nurses is underway to determine responsibilities, practice setting, education, remuneration and legal protection /status of nurses working in various community settings. A random sampling of about 8,000 of the estimated 14,000 nurses in these settings have received a questionnaire. Analysis of the returns is currently being carried out and will yield national baseline data on nurses practising in community-based health services. The analysis is scheduled for completion by December 1976 and a final report for early 1977. These data should provide a basis for further national studies.

- *Health Promotion Program for Nurses*

A follow-up program on nurses who completed the Health Hazard Appraisal at the 1974 annual meeting was undertaken and a health promotion program was developed in collaboration with Recreation Canada. A pilot project on "Health Promotion for Nurses" was implemented, with the cooperation of RNAO, at the Toronto General Hospital, Nursing Staff Development Department. The project was aimed at raising nurses' awareness of their own health standards and promoting changes in their lifestyles. Some of the measurement tests demonstrated at the convention in Winnipeg (1974) were used by the participants to determine their state of health. They were then provided with fitness programs suited to their individual needs.

A national program, with a "workshop on fitness and lifestyles," initiated at CNA house in February 1976, has as its major aim the measurement of the "health status" of individual nurses and assistance to change their lifestyle in a way which will promote better health. This workshop was attended by a representative from each provincial nurses' association and one from NWTRNA and it included participation in fitness tests and presentations on various aspects of fitness as a method of disease prevention. Participants learned how to administer the Health Hazard Appraisal questionnaire and the Canadian Home Fitness Test in preparation for planning regional workshops. With this experience and the aid of a grant from Recreation Canada, representatives then set up a Health Promotion Program for nurses in their home province or territory.

- *National Standards for Nursing Education*

The Board of Directors appointed an Ad Hoc Committee on Standards for Nursing Education. This Committee's report was presented to the Board of Directors meeting, held immediately prior to the annual meeting. At the time of writing, the Committee was in the final stages of preparing the document which will set out: a rationale for preparation of standards; definitions of terms used in the document; statements of the various steps to be taken by educational instituions in the planning, implementation and evaluation of nursing education programs. Accompanying the draft document will be recommendations regarding: feedback from Canadian nurses regarding the document; revision and/or modification of the document as necessary in the light of reactions; mechanisms through which the final document could be circulated; and mechanisms or strategies through which educators can be helped to make use of the standards.

- *Development of Standards for Nursing Practice*

The development of standards for nursing practice was identified as a priority by the Board of Directors in Feburary 1975. An ad hoc committee on development of a definition of nursing practice and development of standards of nursing practice was established in April 1975 and alternate strategies for accomplishing the task were presented to the Board of Directors. Member nurses' associations have actively collaborated in the work to date and their assistance will be required by the Project Director.

- *Health Status Indicators*

In February 1975, the Board of Directors accepted a recommendation of the Special Committee on Nursing Research that CNA, in collaboration with other professional associations, sponsor a conference if outside funding can be obtained: a) to determine what research needs to be done to develop and test health status indicators; and b) to encourage research projects on this subject.

- *Consumer Rights in Health Care*

The Board of Directors accepted a recommendation of the Special Committee on Nursing Research that CNA, in collaboration with CHA, CMA and CPHA, explore the feasibility of initiating a national project on "patients' rights."

- *Development of Comprehensive Examinations*

A major project of the Testing Service is the development of a comprehensive examination — in French and English — for candidates writing registration examinations.

- *Library and Archives Projects and Programs*

Many projects initiated over the past 10 years have developed into an impressive program during this biennium. Serving all CNA members, students and staff, the Library provides some of the most visible "products" this Association has to offer. CNA Library is a unique and invaluable resource center for members, Board of Directors, committees, staff, teachers, health practitioners and researchers in Canada and abroad. Services are also provided to both the public and private sectors. The National Nursing Archival Collection is growing gradually and now contains a large number of pins, caps, uniforms, medals, stamps, rare books, instruments, gifts from international associations, prints of historic events, photographs, etc.

- *Nursing Abroad Program*

CNA's Nursing Abroad Program is carried on by staff in collaboration with, and under the auspices of, the International Council of Nurses. This program's purpose is to facilitate the movement of nurses from one country to another for reasons of employment, study or observation. The service is offered with the cooperation and assistance of CNA member associations and nursing associations throughout the world. The volume of correspondence, especially with nurses from developing countries seeking study or employment in Canada, increases yearly. During the past year, approximately 1,200 letters were written by staff to foreign nurses seeking study or employment in Canada; 42 visits were made by foreign nurses to Canada; 52 Canadian nurses requested assistance in studying, observing or finding employment in 20 foreign countries; and more than 20 international visitors were received at CNA House. Visitors to Canada, under the auspices of the World Health Organization, their government or agency, are also welcomed at CNA House. Their requests for information on nurses and health in Canada are numerous and span a wide spectrum.

- *Program of the Secretariat*

The on-going program of the secretariat may be considered a "core" function of CNA. The secretariat ensures that all requirements, as set forth in the Letters Patent and By-law are carried out. Staff members provide secretariat services to the Board of Directors, Executive Committee, special and ad hoc committees, make arrangements for annual meetings, election of officers and maintain corporate and financial records.

• *Statistical Program*

Countdown, the pioneering project of CNA to collect up-to-date statistics on nurses and nursing in Canada, has been recognized. This program was started in 1964 and *Countdown* was published annually by CNA up to 1974 when an agreement to publish nursing statistics was negotiated with Statistics Canada.

A publication resembling *Countdown 1975* and *Statistiques 1975* went to press recently. This will eliminate the need for CNA to print *Countdown.* However, the collection of some data — particularly those related to basic nursing education — has reverted to CNA due to budgetary cutbacks by the federal government. CNA will continue to seek the cooperation of provincial registering bodies in obtaining this information. We anticipate that Statistics Canada will carry out this project for a three-year period. Its continuance thereafter will depend upon a budgetary assessment.

• To date, CNA has compiled and maintained a Resource Card File on about 14,000 Canadian nurses who have a baccalaureate, master's, or doctoral degree. Each year, information is collected on nurses who have received their first or higher degree. Information gathered includes: year degree obtained, university granting degree and the major area of study. The need to obtain information on the Canadian nurse population with special expertise has been recognized for some years. CNA receives numerous requests from govemmental agencies and voluntary associations for nurse representation on committees, panels, etc., as well as for assignments in Canada and abroad. CNA now has the capability of maintaining an up-to-date list of several thousand nurses with special expertise and this project is in the developmental stage.

• *Communications Program*

This program touches all aspects of the Association but, specifically, includes production of the two monthly journals, public relations and translation services.

During this biennium, journal policy, format and content have received special attention from the Board of Directors, its ad hoc committee on the journals and staff. Several important recommendations have been implemented. Within the limitations of budget, every effort is being made to ensure that the journal will become a more valuable and visible communication tool. Similarity of format and content between French and English editions is growing. CNA continues to be the only national health-related association that provides each member with a separate monthly edition in the language of choice.

• *Others*

A number of other programs and services are available to members, but only two are noted here. One is the CNA Retirement Plan (CNARP) for nurse members and employees who do not have access to a pension plan. The second is the CNA Loan Fund. CNA provides this service to its members to enable those who qualify to undertake post-basic (baccalaureate or higher) studies in nursing. The total amount available for loans, per year is $8,000 — 10 loans of $800 each.

Liaison Activities

As the national voice for Canadian nursing, the liaison role of CNA is increasing daily. The volume of requests for assistance, information, nursing representation on committees and nursing viewpoints on current social issues or developments has never been greater. They come from international, national, provincial and local organizations, the media, and federal and provincial governments. All organizational units of CNA are involved in meeting these needs.

Much time and effort has been devoted to this function since directors and staff agree that it is through cooperation with external agencies and communication with the public that the contribution of nursing, as a profession, will be recognized. Great strides have been made in promoting the policies and beliefs of Canadian nurses and the Canadian Nurses Association. The contribution and willingness of nurses from all across Canada to serve on committees and task forces is acknowledged and appreciated by directors and staff.

Directors, appointed representatives and staff have been in active communication with about 50 national organizations, more than 24 government departments, in addition to Health and Welfare Canada, and more than 20 international organizations. CNA is a member or affiliate member of a number of these organizations. Details are available on request.

Joint Committees

In addition to these liaison activites, CNA is involved in the work of two important joint committees:

• *CHA/CMA/CNA Joint Committee:* Committee composed of executive officers of three associations. Agenda items discussed at the last meeting, included: Patients' Bill of Rights; ethical aspects of life-sustaining measures; implications of Bill C-68 and Bill C-72; role of midwives; utilization of hospital facilities and influence of health promotion on the cost of health care; transfer of medical functions and endorsement of Medic-Alert.

• *Joint Committee on Extension Course in Nursing Unit Administration:* CNA and CHA have four representatives each. CNA representative is current chairman. To date, over 7,000 nurses have taken this course and, at present, 600 nurses are enrolled. The course is offered in English and French. In addition, the course is offered in Zaire, Haiti and Lebanon. A request from Botswana is being considered.

CNA MEMBERSHIP at December 31.

Association	Year		
	1973	1974	1975
Registered Nurses' Association of British Columbia	13,389	14,646	15,251
Alberta Association of Registered Nurses	10,060	10,698	11,410
Saskatchewan Registered Nurses' Association	6,470	6,617	6,898
Manitoba Association of Registered Nurses	6,007	6,284	6,794
Registered Nurses' Association of Ontario	13,183	14,534	16,398
Order of Nurses of Québec	35,196	38,084	40,954
New Brunswick Association of Registered Nurses	4,339	4,540	4,476
Registered Nurses' Association of Nova Scotia	5,263	5,360	5,723
Association of Nurses of Prince Edward Island	803	842	865
Association of Registered Nurses of Newfoundland	2,442	2,519	3,077
Northwest Territories Registered Nurses' Association			(not reported)
Total	97,152	104,124	111,846

HIGHLIGHTS

from the meeting of CNA directors in Halifax June 18 -19, 1976.

Bill C-68 (An Act to Amend the Medical Care Act): A letter, reiterating CNA's position concerning alternatives to acute care and development of preventive services, was sent to the Minister of National Health and Welfare. Copies will be forwarded to member associations. It was suggested that CNA could best influence this legislation through representation and clarification at the provincial level and through providing data to provincial spokesmen at the next federal-provincial ministerial conference in the Fall.

Report of Principal Nursing Officer: The Principal Nursing Officer identified major issues facing the nursing profession, including: present nursing manpower situation; the need for CNA to consider re-stating its position on basic nursing education; and the problem of relating the philosophy of nursing service to the provision of optimum nursing care. Recommendations and findings of the recently published report of the Canadian Task Force on Cervical Cancer Screening Programs were discussed and directors agreed that this document required further study.

Special Committee on Nursing Research: Members of the board voted to initiate a discussion among representatives of the Canadian Nurses Association, Canadian Nurses Foundation and Canadian Association of University Schools of Nursing to review the development of nursing research in Canada and to suggest a plan for its orderly development in the future, in terms of the policies and responsibilities of the different organizations involved in nursing research, the preparation and development of nurse researchers, the opportunities essential for critiquing research projects and any other aspect the discussion group might deem necessary. The Special Committee on Nursing Research was authorized to establish a subcommittee that will serve as a planning committee for the National Colloquium on Nursing Research scheduled for 1977.

Committee on Testing Service: The Committee on Testing Service has postponed the intended implementation date for the comprehensive examination, scheduled for August 1978, due to insufficient time to produce a quality examination. A revised date for initial use of the examination has not been scheduled. The Committee also reiterated its concern regarding the high cost of developing the examination in two languages and asked for suggestions regarding possible sources of funding. A blueprint for the comprehensive examination, in English, has been developed and presented to the Committee on Testing Service. It is anticipated that the blueprint for the French examination will be completed by mid-August.

Canadian Council on Hospital Accreditation: According to CNA representative, Helen Taylor, an increasing number of survey surveys have been conducted across the country and one area of concern has been identified: the proportion of large teaching hospitals that have received a lower rating or provisional accreditation has become almost twice that of non-teaching hospitals. Medical review and medical records are areas of special concern. The trend seems to be towards accrediting hospitals for two years instead of three. Medical audit has become a requirement for accreditation in the United States and this may become a criteria in Canada as well. CCHA is also attempting to promote the nursing audit. The Mental Health Guide for accreditation of mental health care institutions has been revised and is available from CCHA. It is anticipated that an additional seat for CNA on the CCHA Board may become a reality in the Fall.

Nominations for ICN Board of Directors: Board members approved the nomination of the following as members of the ICN Board of Directors: president, Eloise Duncan, Liberia; first vice-president, Verna Splane, Canada; member-at-large, Nicole Du Mouchel, Canada; area representative, Eileen Jacobi, U.S.A.

Kaspar Naegele Education Fund: CNA and provincial nurses' associations contributed generously to this fund, which was established on the death of Dr. Naegele to ensure that his children received university education. CNA has been advised that all three children have completed, or are completing, their education. Dr. Naegele directed a study on nursing education in Canada, published in 1966 under the title "A Course for the Future."



Resolutions chart new course for national association in 1976 - 78

The Canadian Nurses Association received a strong endorsement of its policies and projects at this year's annual meeting. A proposed increase in membership fees was accorded priority and was moved to the beginning of a long list of resolutions considered by members.

The increase, necessary to keep the association solvent, received the strong support of most members. A lively debate gave rise to several amendments to the original resolution that called for a hike to $12.00 in 1977 and $15.00 in 1978. Finally, a resolution was passed:

- **That the membership unit fee in CNA be $12.00 for 1977 and $18.00 for 1978.**

Debate on the other 30 resolutions was kept short and to the point due to an air strike which disrupted plans and left the question of homeward travel "up in the air." Delegates, anxious to catch chartered flights, buses and trains back to their homes, passed a record number of resolutions covering subjects from patients' rights to occupational health, all in record time. The resolutions that were carried, outlining CNA's official policy, directed:

- That an amendment be made to the letters patent incorporating the Association to change the name from "Canadian Nurses'Association — Association des infirmières canadiennes" to **"Canadian Nurses Association— Association des infirmières et infirmiers du Canada"** and that paragraph D be amended to include the **Northwest Territories Registered Nurses Association** in its list of 11 association members.

- That sections of the by-law be amended to include the following changes: 1) five members-at-large be elected to represent the fields of nursing administration, nursing education, nursing practice, social and economic welfare and **nursing research;** 2) one executive director be appointed by the board and given responsibility and authority for implementation of all Association policies, including the **Testing Service;** 3) a three-member **committee of nominations** be elected at an annual meeting of the Association; 4) the **Testing Service Committee** be established as a standing committee and thus be safeguarded against dissolution other than by a membership vote at an annual meeting.

- That CNA develop a policy statement on **Consumers' rights in health care** using the Consumers' Association of Canada document *Consumer Rights in Health Care* as a starting point for discussion.

- That this assembly urge CNA and association members to exert pressure on governments to enact legislation making it mandatory for employers to make available a **health maintenance and promotion service** for their employees; and
That governments and employers be made aware of the network of nursing services available in their communities as well as the options this network provides in the delivery of **occupational health services.**

- That CNA pursue with legal counsel the feasibility of bringing **tobacco under the Canadian Food and Drugs Act** and that any action be in collaboration with the Canadian Council on Smoking and Health.

- That CNA encourage and promote a program of public awareness regarding the day-to-day physical, social and emotional needs of **children and youth** whether they be sick or well; and
That CNA ask the Minister of Health and Welfare to give priority consideration to the health care and health protection of our children and youth when considering policies and programs that will implement the report *A New Perspective on the Health of Canadians,* Ottawa 1974.

- That the necessary resources continue to be allocated to ensure that the project on **national standards for nursing education** be completed; and
That this project be a priority in the biennium, 1976 - 1978.

- That the necessary resources continue to be allocated to ensure that the project on **national standards for nursing practice** is completed; and
That this project be a priority in the biennium, 1976 - 1978.

- That CNA seek funds to conduct a program for nurses to further their skills in **multi-risk health counselling** in the biennium 1976 - 1978.

- That the CNA Board of Directors continue to urge member associations and ordinary members of CNA to initiate and conduct projects that will advance the development of a **knowledge base,** and of the **practice of nursing.**

• That all CNA members be urged to support the **Canadian Nurses Foundation** so that it can carry out its mandate.

• That this assembly support CNA in its efforts to provide **statistical data** related to registered nurses in Canada and recommends that every effort be made to:
1) maintain statistical tables in a consistent manner so as to maximize their usefulness;
2) fix a publication date that will ensure the availability of current relevant data;
3) revert to the publication of this statistical information in the original format of **Countdown.**

• That CNA in conjunction with member nurses associations and other appropriate health professionals, develop a position statement regarding a realistic distribution of **educational programs for nurse-midwives** in Canada.

• That CNA take leadership in seeking funds to support member associations in the holding of symposia on the subject of **pharmacotherapy** to raise the level of awareness of nurses to their responsibility for being knowledgeable in this aspect of their practice; and
That the holding of such symposia be contingent upon external funding.

• That CNA support Canada's position that each future **UN Conference** remain constant to the purpose of the Conference and not be distracted by political issues and differences that rightfully belong in the General Assembly and the Security Council; and
• That CNA support the **Habitat** Conference resolution on the provision of **clean water for all communities;** and
That CNA endorse Canada's efforts for a target date of 1986 for the provision of clean water, and for a commitment as to budgetary allocations by supporting nations; and
That CNA support the resolutions passed by the International Non-Governmental Organizations (NGO) Conference calling for new institutional arrangements with the UN, including NGO and governmental participation in any future action relating to human settlements.

• That CNA request the Canadian Government to implement the World Plan of Action of International Women's Year to further the **equality of women** in all aspects of national life throughout the 1976 - 1986 decade.

• Whereas, Bell Canada has plans to introduce a new style receiver, the Balanced Armature Receiver, (B.A.R.), that will not provide the electro-magnetic field required to activate the present hearing aid design utilized by persons with hearing disabilities, and since hard of hearing persons will then be denied the benefits of telephone communications, CNA should support the steering committee **"Telephone Receivers and the Hearing Impaired"** in their discussions with Bell Canada to have all B.A. Receivers equipped with "Fluxcoil" so that those with impaired hearing may have the same access to the telephone as they now have.

• That CNA acknowledge the concern of current **English language nursing graduates in Quebec** for their future in the practice of nursing in Canada.

• That CNA go on record as expressing concern to government for the maintenance of existing programs promoting health; and
That CNA urge government to allocate funds for the further development of **health promotion and maintenace programs.**

• That CNA take the necessary steps to ensure that **continuing education** for nurses be a priority during the 1976-78 biennium.

• That Canadian nurses through their professional organizations work closely with federal and provincial governments to develop creative altematives to the present health services by implementing cost effective health care programs which would provide greater choice and flexibility; and
That Canadian nurses, through appropriate channels, call for changes in the **health care delivery system** to ensure that a full range of health programs is readily accessible to Canadians.

• That the CNA Board of Directors consider the problem of inconsistent French **translation of CNA documents** and take the necessary steps to improve translation.

• That CNA take the initiative in inviting all existing **special interest groups** which are of a national character and which are comprised of ordinary CNA members, to become official affiliates of the Association.

• That CNA actively encourage the establishment and development of additional **special interest groups** in nursing which are comprised of CNA members; and
That CNA be prepared to offer at least limited **financial assistance** to such groups for organizational purposes and up to their first two years of operation.
• That the CNA Board of Directors consider reconstituting the **Special Committee on Nursing Research** in order to change its designation from a special to a standing committee.

• That CNA support the continued involvement of the **public health nurse in school health programs.**

• That CNA initiate cooperative action with all relevant nursing groups to ensure that **doctoral programs in nursing** are established to maximize the utilization of scarce resources and accommodate the wide range of educational needs and geographic locations of nurses in Canada.

Two other resolutions were referred to the CNA Board of Directors for consideration:

• That nurses bring to the attention of CNA **products detrimental to health** and that CNA take action towards having these products removed from the market.

• That Canadian nurses, through their professional organizations, promote increased use of existing community nursing services to trace persons with **sexually transmitted diseases** and to help families cope with problems related to these diseases.

THE SLEEP ASSIGNMENT: A WAY TO LEARN PROBLEM SOLVING

In her professional environment, the nurse must continually work towards the solution of the problems that confront her[1]. In fact, it is only by mastering this basic skill as a student nurse that she becomes competent to meet the challenge of advancing technology. In this article, the author describes how she introduced her students to a group experiment in the practical application of problem solving techniques that added appreciably to their skills in this critical area.

Agnes T.H. Choi-Lao

An introduction to the concept of problem solving, which is regarded by many authors as the unique function of the professional nurse[2-5], comes early in the first year for most basic baccalaureate students. Ideally, it is then reinforced by patient assignments in clinical areas throughout the remainder of the program. Most educators, however, would agree with this author that there is room for improvement in current methods of teaching problem solving. Although classroom lectures provide the theoretical framework, clinical patient assignments intended to reinforce the concept are often too complex to make good supplementary learning models. Because their time and resources are limited, students tend to focus only on the patients for whom they must provide direct patient care and to compartmentalize patient problems into need deficits. In their attempts to apply problem solving techniques in everyday nursing practice, these students rely on a variety of sources for the answers they need. These include:

— the theoretical grounding they have received;
—guidance from their peers and supervisors;
— intuition;
— other coping mechanisms.

Convinced that more meaningful experiences in practicing techniques of problem solving could be found, the author looked for a group project for her second-year students that would be based on nursing care and would also represent refinements of learning situations found in everyday life. She decided that the investigative question to be answered by problem solving techniques should deal with physiological needs since these are the most fundamental of all human needs and require constant satisfaction. Further htought also suggested that the topic should be relevant to current classroom instruction since this would encourage immediate application of theory. With these considerations in mind, she formulated this project. "An Assessment of Patients' Sleep Needs."

The project

The specific problem chosen for the project was an attempt to answer the question, "How do patients sleep during their hospitalization?". The purpose of the study was to examine the factors affecting the sleep of patients during their hospitalization (as seen by these patients) and to determine:

- whether or not the sleep needs of these patients were being met;
- if yes, how?
- if no, why not?

All clinical groups of the class participated in the project which was designed as a group assignment. Each group was required to examine the sleep needs of one patient in their particular clinical area. This method was chosen because it was believed that for the second year students, group effort would be fruitful in problem solving. Also, the mutual support obtained from group members would provide the sense of direction they needed for a new and challenging experience.

As soon as the students began to examine the problem, they realized that there were an almost infinite number of related questions they must answer before they could draw a meaningful conclusion. First, a total understanding of the patient's sleep routine at home was essential. Also, the students must examine how the patient's health problems had affected his sleep, both at home and in hospital. Third, they needed to investigate the hospital environment to see if it had any effect on the patient's sleep pattern. Once the students had listed all the possible areas they must examine for data collection, they soon realized that it was important for them to define "normal sleep." Did they mean the duration of sleep as experienced by the patient, or as observed by others, since a discrepancy between the two could occur?

The task of data collection was divided among the group members who were allowed to choose the method they preferred. The interview method was the one common to all groups. Patients' charts were also thoroughly studied. Some students observed patient activities and others investigated environmental factors, in relation to sleep. Hospital and ward manuals, were also examined to obtain relevant data. Before completing the project, students were required to describe their findings and recommendations. These written projects were submitted to the teacher for appraisal and the cases were presented in class for discussion.

Findings

Since the initiation of the project two years ago, a total of 16 patients have been investigated by two classes. These 16 patients voiced a total of 96 complaints over their entire period of hospitalization. Complaints were grouped into five areas in order of decreasing frequency:

1. Health problems
2. Environmental interferences
3. Uncoordinated daily activities

4. Psychological factors
5. Changed personal habits

1. *Health problems:* Patients complained about *pain* more than any other single health problem. They stated that pain prevented them from falling asleep, and that they often awoke from sleep with pain when the effect of analgesics began to diminish. Restricted positioning and dyspnea were cited as the second and third most significant factors causing sleep loss. Patients who were troubled by frequency of micturition and diarrhea also suffered from varying degrees of restlessness at night.

2. *Environmental interferences*: Almost all patients compained about noise. Intercom, Electrovox, elevators, delivery carts, machines, telephones, and other noise-producing operations are used constantly during the day and, at times, in the night. One patient remarked: "After a while, even the Addressograph becomes a nuisance."

One group of students used a cassette to record the noise on the ward at about 13:00 hours — a time considered inactive by the staff. When the five-minute recording was played back later in class, it sounded like a busy railway station. One patient, in response to the questionnaire, wrote: "I find it incredible that radios are allowed to blast constantly ... I can't rest, relax or think. I am grateful that I am not seriously ill, for the radio noise would be very debilitating to my recovery."

3. *Uncoordinated daily activities*: Patients were almost as bothered by the haphazard timing of daily activities on the ward as they were by psychological problems. They felt that these routine activities, scattered throughout the day, were not coordinated with a view to permitting them to obtain their rest and sleep. All patients commented on the poor ward organization and complained about the frequent interruptions which resulted in inadequate sleep. Two patients questioned the necessity of having to be awakened one hour before the arrival of breakfast trays; two other subjects pointed out that missing afternoon naps certainly lessened the total amount of sleep obtained. Only one patient thought that lack of exercise might be one of the major causes for his wakeful nights.

4. *Psychological factors:* Most of these comments related primarily to unidentified anxiety. Two patients were deeply disturbed by the knowledge of their illness. One expressed this feeling directly by saying: "I know I am going to die." Financial worries and concern over family members were also among the factors that caused loss of sleep. One lady said: "The very fact that you are away from home is enough to keep you from sleeping." Another patient reported that a frivolous comment made to him by an orderly had caused him to lose a night's sleep.

Results

Changes in personal habits and daily routine that occur as a result of admission to hospital can also cause sleep deprivation, but few patients commented on this aspect of the study. Results and examination of the data revealed that all patients suffered to a certain degree from sleep deprivation, and all subjects expressed the desire to sleep more.

Students who participated in the project were unanimous in their opinion that action should be taken to reassess and met the sleep needs of hospitalized patients. They listed in order of priority a number of nursing measures that could be taken to minimize sleep loss. These measures were then grouped into the following eight areas:

- meeting the patient's need for comfort
- meeting the patient's psychosocial needs
- administration of medications as prescribed following nursing assessment
- better coordination of nursing activities
- adjustment of physical environment to meet individual sleep need
- meeting the patient's need for elimination
- meeting the patient's need for activity and recreation
- meeting the patient's dietary need

Observations and suggestions: Comfort measures such as positioning, back rubs, a warm bath at bedtime, and comfortable bedding were recognized as important by all the students. The satisfaction of both comfort needs and psychosocial needs was considered by the students to take precedence over the accurate administration of medications, mostly analgesics, sedatives and tranquilizers. They recognized that, although pain was the most frequently cited cause of sleep loss, it was important to meet the other needs of the patient first. Better coordination of nursing activities could do much to improve a patient's daily life while hospitalized. Students proposed that treatments and procedures be organized so that patients could room together according to their level of illness, in order to facilitate nursing care. A rest period during the day was perceived by many student investigators as mandatory. They felt strongly that ward manuals and policies should provide guidelines for meeting the patient's sleep needs. Students readily recognized the need to regulate room temperature and humidity, and to rearrange curtains and lighting to meet individual demands.

There was a great deal of discussion about methods of reducing the level of noise on the wards. One group of students even investigated the cost of using a bell boy paging system instead of the existing Electrovox and intercom systems. Others investigated the bus route in front of one of the hospitals and concluded that the route should be changed.

Frequency of micturition caused some sleep loss. Lack of activity could reduce the need for sleep. Students viewed the promotion of proper activity and recreation as interrelated with promoting sleep. The provision of flexibility in meeting patients' dietary needs was also discussed. One patient remarked that he would sleep better if bedtime snacks were available. Since all wards have unit kitchens, this problem was not difficult to solve.

Summary

The project revealed that hospitals clearly could and should do a better job of meeting the sleep needs of their patients. The most significant finding, however, was that the majority of problems identified could be corrected simply by modifications in the nursing modus operandi. The students took great pride in their ability to improve nursing care, and they also proposed, for future nursing practice, the following six recommendations:

1 THAT ward routine be organized to promote patient-centered nursing care.
2 THAT a rest period in the afternoon be made available to all patients requiring it.
3 THAT the noise level on wards be reduced to a minimum in order to provide a restful environment.
4 THAT the physical environment be made conducive to sleep.
5 THAT the individual patient's sleep pattern at home be inquired into and recorded on admission in order to identify needs.
6 THAT in-service programs be initiated to educate and update hospital personnel to sleep needs of patients.

It is evident to the writer that the students were responsive to the existing problems in nursing and were oriented to the application of the first level of research. All of the participants in the project acknowledged that their skills in problem solving had definitely improved; the experience and knowledge gained was unique and meaningful. Like all projects, the sleep project will be continuously refined. Eventually, it is hoped that it will help to make problem solving an inseparable part of the nursing curriculum and a natural and most fundamental part of nursing practice.

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The author wishes to express her appreciation to her colleagues and to the students of Classes 1976 and 1977, School of Nursing, University of Ottawa, for their participation in this project.

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Chemical neurotransmitter substances are released at the axon terminals of the central, autonomic, and peripheral nervous systems of the human body. The most well-known of the neurotransmitters are acetylcholine, norepinephrine, dopamine, and serotonin. It is these substances that facilitate the conduction of nerve impulses throughout the body, allowing the coordination of body functions and enabling response to the environment. The effective action of neurotransmitters makes the difference between health and disease states. A nurse's understanding of neurotransmitters and of many common drugs influencing their function is essential to safe nursing practice.

Understanding

Barbara Doughty and Julie Crozier

The nervous system and the endocrine system have the task of maintaining coordination of the many activities of the body and of preparing its responses to the external environment. Nerve impulses are transmitted along a network of nerves with many interconnections in all parts of the body. Here we shall examine *chemical neurotransmitters,* the agents that make possible the transmission of impulses from one nerve cell to the next, and the effects of common drugs on these neurotransmitters.

How Nerve Impulses Travel

The basic structural and functional unit of the nervous system is the nerve cell or *neuron.* It is on this cell that all nervous function ultimately depends. The neuron consists of a cell body with a group of extensions called *nerve fibers* emanating from it. (See figure 1) The nerve fibers can be divided into two groups:

1. the *dendrites* — the multiple branched extensions conducting nerve impulses toward the cell body.
2. the *axon* — a single long extension branching into many fine *nerve terminals* and conducting nerve impulses away from the cell body.

Conduction of a nerve impulse depends on its transmission from one cell to the next. It is at the *synapse,* the junction between the axon of one neuron and the cell body and dendrites of another neuron that chemical neurotransmitters are released to allow for transmission of the impulse.

The synapse, the junction between two neurons, is specialized to allow the electrical activity of one neuron to influence the excitability of a second neuron temporarily. A nerve impulse is conducted along the axon to the *synaptic knob,* a slight swelling at the end of the *presynaptic* neuron. (See figure 2) A narrow extracellular space called the *synaptic cleft* between the presynaptic and *postsynaptic* neurons prevents direct transmission of the impulse from one cell to the next. It is at this junction that the electrical potential of the nerve impulse is transformed into chemical activity.

Impulses travel from one neuron to the next in the following way:

1. The nerve impulse, or *action potential,* in the presynaptic neuron reaches the axon terminal and depolarizes the synaptic knob.
2. Quantities of chemical transmitter are released into the synaptic cleft by diffusion. (These transmitters are stored in *vesicles* in the synaptic knob).
3. The transmitter combines with reactive sites on the postsynaptic cell.
4. There is a localized change in cell membrance permeability resulting in the movement of sodium and potassium ions across the membrane.
5. The chemical impulse begins again in the postsynaptic neuron, and continues as an electrical impulse.

More recent theories suggest that the transmitters are produced in the cell body itself and are carried down the axon by axoplasmic flow to be stored in the presynaptic knob.[1]

Specific enzymes break down these transmitters in the synaptic cleft. Once the transmitters have depolarized the postsynaptic membrane, they are destroyed by these enzymes, leaving the neuron to be repolarized for a subsequent impulse.

Synapses do not occur exclusively between neurons and neurons. They also occur between neurons and motor end plates and between neurons and smooth and cardiac muscle cells. Depending on the function of the neurons involved, different chemical transmitter substances are released. They function either to encourage the postsynaptic neuron to produce nerve impulses (excitatory) or to discourage nerve impulses (inhibitory).

Table 1 indicates some of the better known neurotransmitters, their sites of release, breakdown, and the body responses they are thought to effect.

Alterations in the concentrations of neurotransmitters contribute to disease states. Parkinson's Disease and Myasthenia Gravis are two commonly known conditions associated with such changes. Less common conditions include the poisoning effect of strychnine, muscarine of certain mushrooms, the venom of snakes and Black Widow spiders, and tetanus toxin.

Synapses are vulnerable to many drugs and toxins which can —

- modify the synthesis, storage, or release of the transmitter substance
- interfere with the breakdown of the substance so that its action is abnormally prolonged
- block reactive sites on the postsynaptic membrane to prevent combination with the transmitter.

Many of these drugs are commonly used; therefore their actions in relation to the normal function of neurotransmitters ought to be understood by nurses to ensure the safe administration of such drugs.

NEUROTRANSMITTERS and related drugs

Figure 1 Several neurons

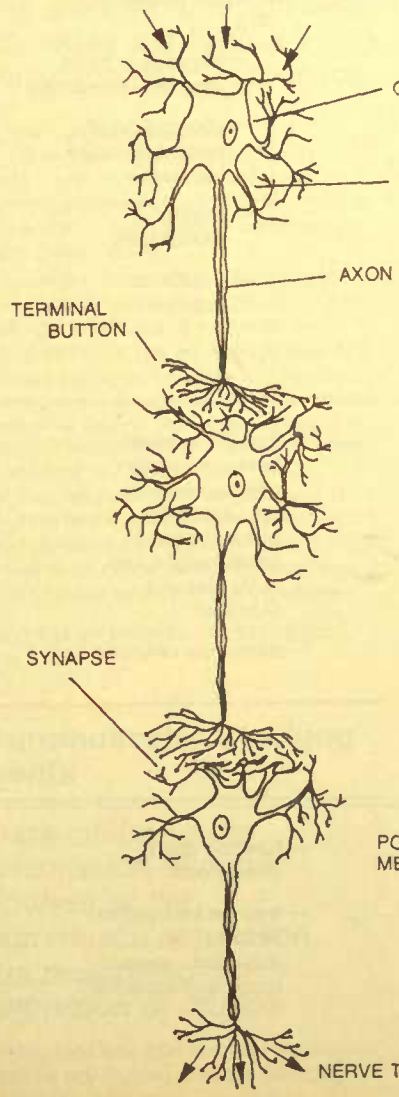


Figure 2 Synapse at the Neuro-muscular Junction

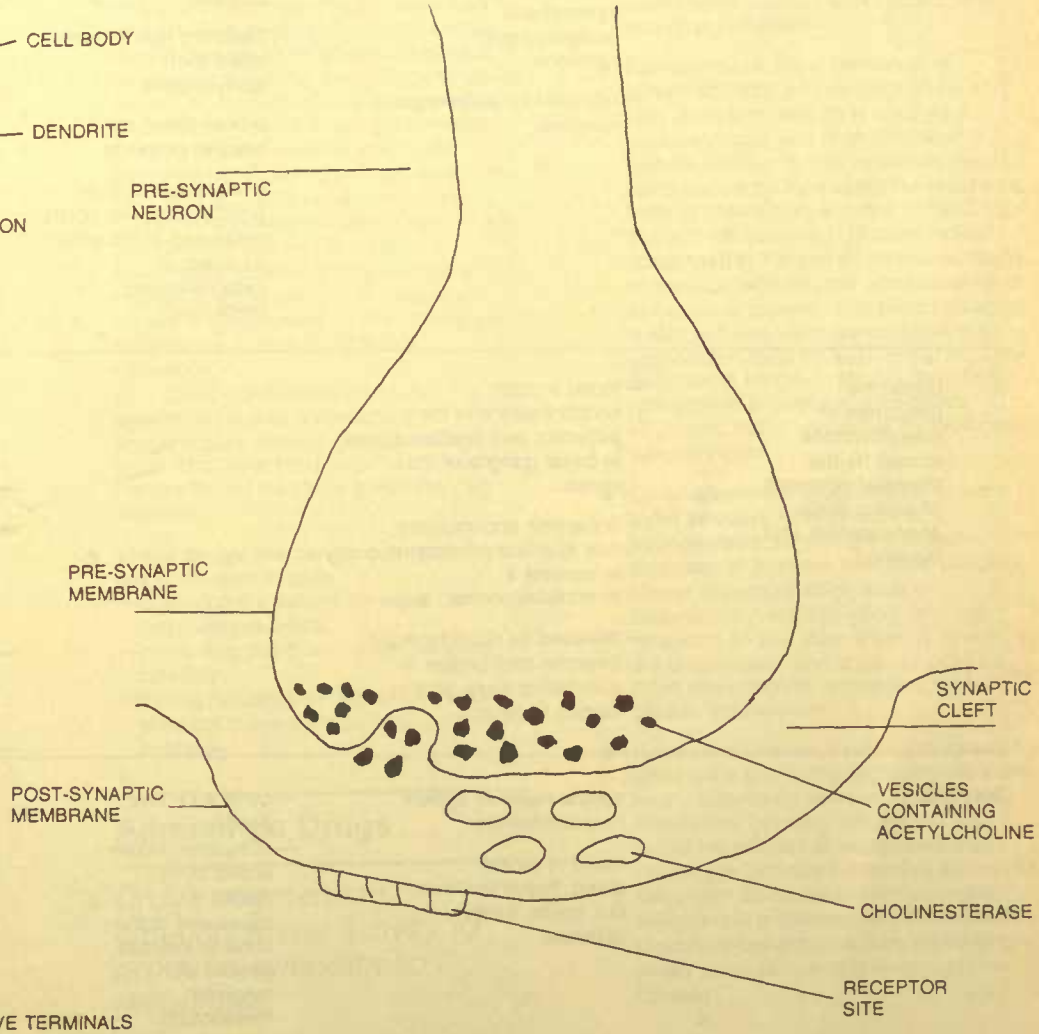


Table I

Transmitter Substance	Site of Action	Breakdown	Body Response
Acetylcholine	— released at a) the neuromuscular junction b) the preganglionic terminals of the autonomic nervous system c) the postganglionic terminals of the parasympathetic nervous system d) the postganglionic terminals of the sweat glands in the sympathetic nervous system — released by *cholinergic* neurons	— by the enzyme *cholinesterase*	a) skeletal muscular contractions b) parasympathetic responses, eg. — decreased heart rate and contractility — pupillary constriction — increased gastrointestinal secretion and motility — increased sweating
The Catecholamines 1. Norepinephrine 2. Epinephrine	— secreted by the adrenal medulla — released at the sympathetic postganglionic junctions — released by *adrenergic* neurons	— rapidly removed from the synapse by M.A.O. (monoamine oxidase) — therefore has shorter effect than acetylcholine — broken down into inactive products — end product V.M.A. (vanillylmandelic acid) measured in the urine as a test of catecholamine breakdown	— sympathetic "fight or flight" response eg. — increase in heart rate and contractility — constriction of peripheral blood vessels — dilation of bronchioles — dilation of pupils
3. Dopamine (precursor of norepinephrine formed by the chemical reactions of amino acids phenylalanine and tryosine)[2]	— found in high concentrations in the putamen and caudate nuclei in basal ganglia of the cortex — dopamine accumulates, due to a lack of enzyme to convert it to norepinephrine — released by *dopaminergic* neurons (cell bodies in substantia nigra, end in corpus striatum)		— thought to relate to motor function and aggressivity eg. Dopamine concentration in basal ganglia low in Parkinson's Disease[3] — exact role unknown
Serotonin	— central nervous system neurotransmitter — found in pineal gland, hypothalalmus G.I. tracts, blood platelets	— by M.A.O. into 5HIAA — (5-hydroxyindole - acetic acid) 5HIAA is measured in the urine to indicate degree of serotonin metabolism	— function poorly understood — may be involved in temperature regulation, sleep, mood and behavior

Transmitter Substance	Site of Release	Breakdown	Body Response
GABA (gamma amino butyric acid)	— transmitter at inhibitory synapses		— inhibitory effect on cerebrum and cerebellum but not on spinal cord[4]. — thought that seizures are a result of decreased levels of GABA.
Others: histamine, substance P, vasopressin, oxytocin, releasing factors of the hypothalamus, prostaglandins			

Cholinergic Drugs

- *Chemicals acting at the same sites as acetylcholine to increase the body's parasympathetic responses*

- Two main modes of action:
  1. direct-acting drugs structurally related to acetylcholine, or synthetic substances that substitute for acetylcholine eg. Urecholine has selective action for the GI and urinary tracts
  2. indirect-acting drugs, causing an increase in the release of acetylcholine by inhibiting the release of enzymes which destroy acetylcholine eg. Prostigmine and derivatives such as Tensilon and Mestinon are used in the diagnosis and treatment of Myasthenia Gravis. Although the exact etiology of Myasthenia Gravis is disputable, this disease is characterized by an abnormal fatiguability of muscle, and is thought to be the result of poor transmission of acetylcholine across the synapse. Drugs like Mestinon inhibit cholinesterase, thus prolonging the activity of acetylcholine.
- Atropine is an antidote for cholinergic drugs.

Neuromuscular Blocking Agents

- *Drugs inhibiting the transmission of nerve impulses at the neuromuscular junction, thus prohibiting the contraction of muscle*

- Can produce fatal effects due to respiratory paralysis eg. Curare, and the toxin of Clostridium Botulinum (Botulism)
- Two main modes of action:
  1. drugs competing for receptor sites with acetylcholine at the motor end plate eg. Curare. Atropine, Belladonna Alkaloids, and Scopolamine also compete for receptor sites at the post-ganglionic parasympathetic synapses. They are more readily accepted by receptor sites than acetylcholine at smooth muscle, cardiac muscle and exocrine glands, causing a decrease in sweating, salivation, and gland secretion. Atropine also causes a reflex vasodilation. These drugs are commonly used as pre-anaesthetic agents, as antidotes for cholinergic drugs, and in the treatment of bradycardia. Artane and Cogentin, cholinergic blocking agents, are used in the treatment of tremors in Parkinson's disease. The presence of tremors in Parkinsonism is thought to involve a hyperactivity of the cholinergic system due to lack of inhibitory influences.[5]
  2. drugs preventing muscular contraction due to a persistent depolarization which eventually renders the motor end plate inexcitable[6] and thus causes flaccid paralysis to develop. eg. Anectine
- **These drugs are dangerous.** Nursing responsibilities include:
  —observing the patient for signs of respiratory distress
  —monitoring pulse and blood pressure carefully
  —having resuscitation equipment and antidotal drugs such as Neostigmine available.

Adrenergic Drugs

- *Drugs augmenting catecholamine activity to produce sympathetic responses.*

- The response of the sympathetic nervous system depends on which peripheral receptors the drugs innervate. There are thought to be two receptor sites:
  1. alpha receptors — responsible for vasoconstriction, mydriasis and pilomotor contraction
  2. beta receptors — responsible for vasodilation, cardiac acceleration, and bronchial relaxation[7]
- Epinephrine, a direct derivative of norepinephrine, acts on both alpha and beta receptors, and so is used as a vasoconstrictor and bronchodilator in asthma attacks. It also increases cardiac performance by increasing the heart rate, force of contraction and rate of conduction through the ventricles. In bronchioles constricted by histamine, cholinergic drugs, or nervous reflexes, the administration of epinephrine causes rapid bronchodilation. It also reduces vascular congestion by vasodilation, thus increasing vital capacity. Because of its rapid rate of catabolism, epinephrine is useful in emergency situations, but is unsuitable for prolonged administration.
- Other adrenergic drugs appear to have more selective sites of action. Vasopressors act primarily on alpha receptors to increase the blood pressure. Newer bronchodilators, such as Salbutamol (Ventolin) affect only beta receptors so that their action is specific to the bronchioles, and does not produce other physiological responses, such as cardiac acceleration.
- In the central nervous system, drugs act by altering the levels of catecholamines in the brain. Autonomic nervous system stimulators, primarily amphetamines, cause the release of norepinephrine, resulting in increased alertness and mood elevation.[8] Because of their secondary vasopressor properties, and their tendency to produce dependence, they are no longer widely used as "psychic energizers" in Canada.

M.A.O. Inhibitors

- *Drugs inhibiting the breakdown of catecholamines and serotonin, causing an elevation of these levels in the brain, sympathetic ganglia, and peripheral tissues.*

- Clinically used as anti-depressants, eg. Niamid, Marplan, Nardil, Parnate. The increased levels of norepinephrine and serotonin have been experimentally associated with mood elevation. However, these drugs are being used with less frequency since they cause adverse reaction with many foods that contain the chemical tryamine (eg. found in aged cheese, pickled herring, chicken liver, some broadbeans, beer, and certain wines). Instead, tricyclic compounds, such as Tofranil and Elavil are being used as antidepressants. Their action interferes with the uptake of released norepinephrine by adrenergic fibers, thus prolonging the action of the neurotransmitter and elevating norepinephrine levels in the brain.

Adrenergic Blocking Agents

- *Drugs blocking the catecholamines at either alpha and/or beta receptor sites, producing specific effects.*

- Alpha blocking agents, eg. Regitine and Priscoline, act on alpha receptor sites to block the vasoconstrictor effect of norepinephrine, resulting in vasodilation and a decreased blood pressure. Such drugs have been used in the past as antihypertensives and for peripheral vascular disease, but now drugs with a more direct effect on arterioles have proven more efficient in these cases.

- Beta blocking agents compete with norepinephrine at beta receptor sites and have their effect on cardiac activity. They act in two ways:
  1. by blocking sympathetic innervation to the heart, to produce a decrease in heart rate and contractility eg. Inderal, used for cardiac arrythmias, for the reduction of frequency of ectopic beats, for decreasing the heart rate and slowing impulse conduction.
  2. by depleting catecholamines and preventing their release[9] to produce a lower level of amines in the nervous system and consequently, a decreased sympathetic response. eg. Reserpine, Ismelin, and Aldomet, used as antihypertensives.

- Hypnotics and anti-anxiety drugs are under investigation to discover if induced low levels of catecholamines are related to their sedative effects, eg. Reserpine depletes catecholamines, and Chlorpromazine (Largactyl) blocks dopamine activity and can produce Parkinson-like symptoms.

Drugs Affecting Serotonin

- *A neurotransmitter under recent investigation.*

- It has been linked with temperature regulation in the hypothalamus, sleep, mood, and behavior. Research has been based on evidence that the hallucinogenic drug L.S.D. inhibits serotonin. Therefore, low serotonin levels are linked to psychotic behavior with hallucinations.[10]

- Recent experiments show that serotonin levels and sleep are related,[11] suggesting that hypnotics and sedatives, eg. barbiturates, alter the level of serotonin. Much of the research also indicates that sedative-hypnotics decrease levels of norepinephrine, epinephrine and dopamine as well.

Drugs Affecting Dopamine

- *A neurotransmitter included in the catecholamines, characterized by selective activity that differentiates it from norepinephrine.*

- Dopamine is primarily found in the basal ganglia and low concentrations of it are associated with Parkinsonism.

- Within recent years drugs have been synthesized to elevate levels of dopamine and treat some of the symptoms of Parkinsonism eg. bradykinesia and rigidity. Since dopamine does not cross the blood-barrier to the brain, direct administration is ineffective. However, its precursor, L-dopa is able to cross the barrier and can therefore be used to elevate dopamine concentrations. The discovery of L-dopa has revolutionized the treatment of Parkinsonism and allowed patients previously severely handicapped to live more active lives. More recently a new preparation — Sinemet has emerged on the market. This drug has the same benefits as L-dopa but reduces some of the unpleasant side effects, particularly nausea and vomiting.

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Nurses who wish to return to the profession after being inactive for several years will encounter a confusing number of changes in new procedures as well as in the professional attitudes of more recent graduates. Historically, the returning nurse was hired and retrained on the job. But current staffing patterns and health care economics mean that this type of retraining is becoming less feasible. In North America, refresher courses have emerged to meet the demand of returning nurses to "catch up" on new theory and skills, and remobilize their nursing abilities. Available at various educational institutions and health agencies throughout Canada, these courses aim to update nurses in a variety of topics and give them clinical experience within a few months. They enable the nurse to refamiliarize herself with basic nursing skills and achieve confidence and competence in nursing patients with common conditions. With this background, they should be prepared to find employment and continue learning within that setting.

Here, Bettie Scheffer shares some perspectives on refresher courses, and outlines the one she is involved in at British Columbia Institute of Technology. For a different viewpoint we look at a diary that records Heather Nelson's reflections while attending a refresher course at Algonquin College in Ottawa. Her honest appraisal of her reactions and thoughts will probably strike a familiar chord with many nurses.

REFRESHER

Bettie Scheffer

In the last 15 years many significant changes have taken place in nursing practice and responsibilities. The nurse who decides to return to the profession after an absence of several years will find changes in her relationship to patients and to other members of the health team. More and more frequently she will be called upon to provide leadership and direct the activities of auxiliary staff on the health team. She will find, also, that the "service" orientation of nursing has given way to an emphasis on total patient care. Spare time that may have been spent in "busy work" previously, is now devoted to therapeutic listening, patient teaching and more complete psychological care. New equipment, removal of sterilizers from the utility room, disappearance of acute cardiac patients from general wards and the introduction of disposable equipment are only a few of the other changes that will require adapting to and will claim the returning nurse's energies.

Understanding new techniques, remastering old skills and, in addition, simply acknowledging the phenomenal medication explosion are not small accomplishments. As a means of assisting the returning nurse to "catch up" in her profession, refresher courses are becoming more widely accepted. A search through published data and a survey of ongoing courses or studies being carried out to establish guidelines helps put this trend into perspective.

Cooper and Hornback have published helpful information regarding the basic methodology in setting up refresher courses, based on several years experience at the University of Wisconsin Extension Division.[1] A course outline and summary of eight years of programs at the Beth Israel Medical Center was described in an article in the American Journal of Nursing.[2] The British Columbia Institute of Technology, in collaboration with the RNABC, has conducted 24 refresher courses since 1972. Three hundred and forty-four nurses have completed this program. Some data describing these courses is presented on page 44. A committee of the RNABC recently carried out an extensive survey to establish expected competencies of refresher graduates as perceived by practicing nurses in staff and supervisory positions. Results of this survey will be used in the process of setting out guidelines for courses in the

BCIT Refresher Course Details

1 Description

Central objective: The nurse demonstrates confidence and competence in nursing medical-surgical patients with common conditions.

Course length: 8 weeks full time; 10 weeks, 4-day week

Enrollment: 12-15 students per course depending on clinical quota
Faculty-student ratio: 1 instructor and 1 assistant per class.

2 Questionnaire survey results

Average age of applicant: 42 years

Average years inactive: 16 years (range: 5 to 25 years)

Employed following course: 60/80 respondents

full time: 29/60	acute care: 43/60
part time: 31/60	extended care: 31/60
relief: 10/60	other: 6/60

3 Topics of study

Stress and adaptation

Hazards of immobility

Inflammation and immunity

Normal aging process

Acid-base, fluid and electrolyte imbalance implications

Death and dying

The nursing process

Therapeutic communications

Common medical and surgical conditions and related nursing care

Drug therapy for conditions studied

Basic nursing skill practice

Metric system conversions

Administration of medications

Sensory deprivation awareness

Cardiopulmonary resuscitation

Intravenous, CVP management

Charting workshop — problem-oriented records

Guest lectures: Contemporary pediatric, psychiatric and maternal-child nursing; role of physiotherapist, social worker; X-ray and radiological procedures; patient preparation

Clinical assignments: Medical; surgical; pediatric; extended care units; PAR, OR, ICU observation and participation

Text used: Medical-surgical nursing: a psychologic approach by Joan Luckmann and Karen Creason Sorenson. Toronto, Saunders, 1974.

4 Cost factors

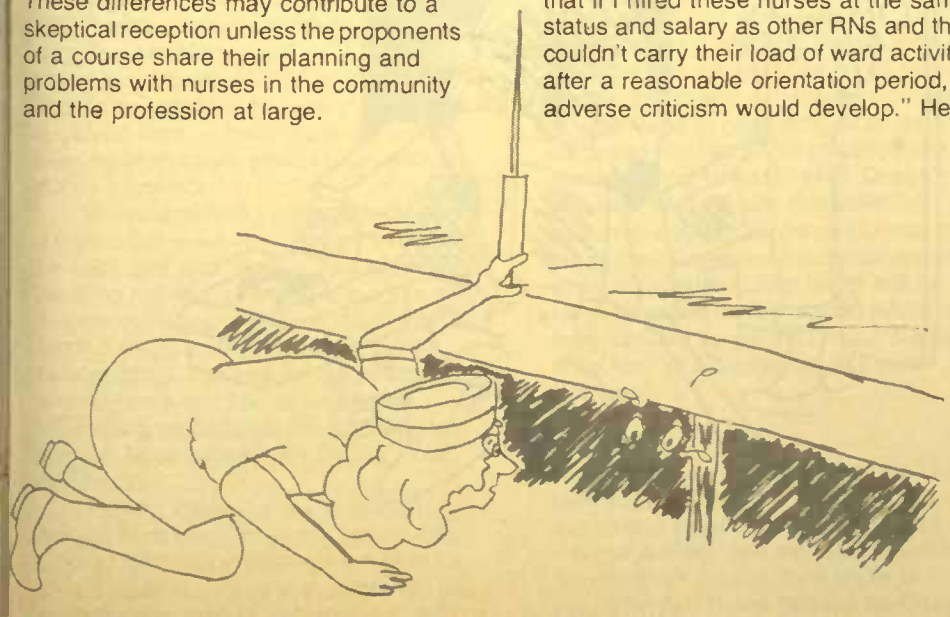
Cost per course '75-76:	$11,600 (96 students 7 courses)
Tuition paid by student:	$290 (per 240-hr course)
Cost per student '75-'76:	$846 (avg. over 1 yr)
Manpower contract (for 54 students):	$561 (per student for 3 courses)

province. In Manitoba, the Provincial Department of College and University Affairs has recently been funded to carry out a Manpower Training Improvement Project to survey refresher course practices in Canada and design curriculum modules for independent study. At present, only one Canadian province, Saskatchewan, has a specific reference to refresher course completion in their Nurses' Act. Information about variations in provincial regulations, and roles and functions of nurses in Canada is published in *Contemporary Issues in Canadian Law for Nurses* by Good and Kerr.[3]

The establishment and scope of retraining programs is limited by the financial support available. Both of the American programs cited above were supported by federal funding, although no cost factors were included in the publications. Item 4 shows some very real economic concerns related to the BCIT refresher course programs; while participants have received financial support from Manpower and Immigration in the past, current economic pressures may restrict such funding.

Refresher courses are usually established in accordance with the health needs of the community and the orientation of the educators and participants involved. Thus, the length, content and objectives may vary significantly from one course to another. These differences may contribute to a skeptical reception unless the proponents of a course share their planning and problems with nurses in the community and the profession at large.

One common approach of many refresher courses is an orientation towards individual support. To meet the unique needs of a typical refresher course student, presentation methods have been geared towards overcoming her feelings of inadequacy and lack of self-confidence. Out of 139 BCIT refresher course participants, 129 rated "close and encouraging instructor participation in the classroom and clinical situation" as very valuable in a course evaluation form. This is a rewarding but costly method of instruction, and alternatives such as independent study units or centralized teaching using educational media need to be considered. Shirley Adams describes a program incorporating self-study units in the education of returning nurses.[4] Programmed learning is already a common feature of continuing education and has proven useful in my experience with refresher nurses. Theory presentation is more amenable to individual pursuit than development of clinical skills and nursing responsibilities. Choosing the type and amount of practice opportunities that will maximize the nurse's previous knowledge and skill is an intriguing challenge. Comments like those of Virginia Walker,[5] director of nursing in an Ohio hospital, imply that current methods have not been completely successful in attaining high levels of clinical performance. "I realized that if I hired these nurses at the same status and salary as other RNs and they couldn't carry their load of ward activities after a reasonable orientation period, adverse criticism would develop." Her solution was to place refresher graduates under the guidance of a staff instructor and employ them at a practical nurse salary. "Most of the returned RNs required from 1 to 3 months to assume routine staff nurse duties."



No systematic attempt has been made to acquire feedback from employers in B.C. hospitals, but none of the 80 RNs who responded to the BCIT questionnaire were employed as practical nurses, and 54 percent were working in acute care areas. This does not necessarily contest the fact that refresher nurses returning to employment experience difficulties, but perhaps reveals a difference in perspective. Cooper states, "At best, a refresher course is only the beginning step toward a return to practice. No course ever replaces an adequate orientation to a specific position in nursing or supportive supervision throughout the early employment period."[6] I have shared this viewpoint with many nurses during courses and realize that very few individuals perceive the course as meeting all their learning needs to return to practice. Most express a firm commitment to continued study, and intend to discuss their current level of competence with potential employers. They anticipate continued growth and increased competence as a natural consequence of active practice.

Despite the fact that refresher courses are gaining wider general acceptance, they are still met with reactions ranging from skepticism (usually on the part of hiring agencies or practicing nurses) to enthusiastic support (from participants and promoters of courses). As an educator involved in planning and teaching refresher courses, I am concerned with their reputation, and as a member of the nursing profession, I am eager to see this method of retraining improved to satisfy the expectations of all concerned. As long as the profession attracts mainly women, and women continue to combine the demanding roles of wife and mother with their careers, the need for retraining programs will continue to exist at a relatively constant level. Consequently, nurses as individuals should look at refresher courses with a personal concern for the ways and means of returning to practice should they experience a need in the future.

As a practicing nurse, where do refresher course graduates fit into your

scheme of things? Their teachers have tried to provide them with learning situations and on-the-job experience. While few returning nurses expect to have learned in a few short weeks *all* the new material and situations they will meet, they usually enter the profession with basic skills and the incentive to continue learning on the job. Their more experienced colleagues can help further refresher goals by providing educators with input about contemporary role requirements that seem to merit more attention in refresher courses.

At the same time "reality shock"[7] is a fact of life for refresher nurses as much as for other graduates. In fact, in many cases we are dealing with people who have previously left their profession because of disillusionment with nursing. While this problem can, to some extent, be counteracted by including those elements which may contribute to "reality shock" in refresher courses, employers and colleagues of returning nurses must be aware that they often experience the same conflicts that new graduates do.

Many facets of the refresher course question still remain unanswered. Is there a "point of no return" when the length of absence from active practice makes it unlikely that a nurse can attain contemporary requirements for employment? What are the magical components of a course curriculum that meets the needs of returning nurses? Will the cost of retraining phase out refresher courses as happened with "on-the-job" methods?

Given the diversity in the education and experience of individuals returning to nursing, it is relatively improbable that any one formula for a refresher course can be agreed upon. Whether the answer lies in practical nurse status initially, longer orientation programs, or more lengthy and specialized refresher courses is yet to be determined.

Larousse International Dictionary defines a refresher course as "a course of study to bring one's knowledge of something up-to-date." In nursing, we must add to that, the complex task of updating one's ability to perform utilizing that knowledge. The means we use to meet this challenge will reflect the viability of reabsorbing inactive nurses into a changing profession. I, for one, am hopeful that the challenge can be met and that it will be refreshing!

Bettie Scheffer (B.S.N., University of Wisconsin, Madison, Wisconsin) is an Assistant Master and Instructor of Refresher Courses at the British Columbia Institute of Technology in Vancouver, B.C. She taught previously at UBC School of Nursing and at St. Mary's School of Nursing in Madison, Wisconsin.

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Diary of a Retread

Heather Nelson

In November 1975, after seven years away from nursing and with a great deal of apprehension, I undertook a 6-week intensive nursing refresher course at Algonquin Community College. At the initial orientation, the instructors emphasized their interest in receiving feedback from students about the course. I kept a diary throughout the six weeks, usually jotting down my reactions last thing at night, and finally submitted it as part of my course evaluation. These are excerpts from the diary.

1st week

Monday

Didn't sleep a wink, of course. Too nervous. Swung between thinking "it's been too long and why am I doing this?" and "if you could cope at 17, you ought to be able to manage at 35."

Introduction by S. She seems genuinely concerned with our learning experience — obviously trying to encourage us to test ourselves — can she keep that up with us old-timers?

Neoplasm pretest and explanation of Dacums. They look like one heck of a pile of work. No way to absorb each one in one week — good for continual study and reference, I would imagine.

Home early, thank goodness. Head swimming. Stomach in knots.

Tuesday

To hospital in a.m. — surgery first — OK. Postop always seemed more common-sense oriented — if not too many procedures are radically different, I should be alright (I keep telling myself.) Explored floor — fortunately it's small. Nursing staff seem comfortable with our dumb questions.

Picked a patient for tomorrow — such a production — wavering between finding an easy one and skating through and learning nothing, or trying a toughie and maybe not doing a good enough job. B. helpful and supportive. Doesn't push. Encouraging. I picked an old postop — should leave me free to watch the interesting procedures I'm not confident enough to do myself yet. Or am I just chicken??

Feeling lonely for my kids today. Miriam finds the p.m. at the sitter's long. Could I do this indefinitely? No time for Butch either — just beat at night. And this is only the second day. My feet hurt. And I lost 2 pounds! Not that that's bad. But basically a let-down feeling today.

Wednesday

Wasn't so bad after all! My patient had the good sense to be discharged before I could get my hands on him, so I asked B. if I could float. She countered with a suggestion that I follow the team leader around. A little whirlwind from Kingston — practically a classmate. She was into everything, so it was a really good deal. Good nurse too— combines a sort of offhand insouciance with a concern for the patient and a surprising knowledge of the whys and wherefores.

Team conference in p.m. was interesting — I was supposed to be "team leader" for our group and ask pointed questions re care, etc. Nothing stupendous, but didn't make a fool of myself. Funny to see the ideals of classroom nursing tempered by the realities of doctors' quirks, hospital procedures etc., like the man undergoing multiple tests for possible carcinoma of the lung and getting progressively more scared, and nobody telling him what was suspected because the almighty MD hadn't decided to yet. Still, the doctors do have a point. Somebody must take ultimate responsibility. Maybe the ideal would be a stable enough staff that the doctors and nurses could *trust* each other! Dreamer.

Scheduled lecture from pharmacologist. Bright young man telling us all about unit dose system. Tremendously efficient, but couldn't get over the pollution caused by all those disposable items, and the unreclaimable energy used in producing what gets disposed of! I raised the question and got patted on the head. Unreal. Doesn't whoever plans these monumental switch-overs realize we can't keep on doing this? Glass and foil containers used once and that's it. The boom will be lowered in the not-so-distant future and hospitals will be up the creek. Wonder what kind of a budget all this stuff requires?

Thursday

Day of classes — mostly with S. That lady knows her stuff. I don't think I'll ever get to that point. Did neoplasm test and trauma pretest. Are we really finished neoplasms? What I don't know is monumental. Thank heaven for Brunner.

Saw a Trainex film. Great idea for individual study.

Friday

Library orientation. Wow — great place. Spent the day there and got a lot done. Love libraries.

2nd week

Monday

Hard to reconcile the facts of kids and house and husband with STUDY. But the family's great, bless them. On the weekend, caught Mike saying proudly to his buddy, "My Mom's studying." Made my day.

Today went over neoplasm tests and trauma pretest with S., and orthopedic splints as well. I really like those tests. Makes me feel less inadequate, because basically I can do them with few mistakes — but enough discussion comes out of them to flesh out my basic knowledge. Enjoy the round table participation. Also am beginning to appreciate my fellow students now that they are emerging as people with names, families, and difficulties much like my own. Nice group.

In p.m., to hospital to pick out patients — feel a little more confident this time. Nursing care plans still a mystery to me. Are they just a busy-work deal or do they really help in communication between nursing shifts and promotion of better patient care? Most of the other women feel much the same way — wait and see.

Tuesday

First real day of patient care and do my feet hurt! A real problem coming home at the end of a working day and having to be giving and bright with my kids. Beginning to empathize with my husband more — but I'll bet his feet don't get as sore as mine!

Did a suture removal and two compresses today. Incredibly nervous. B. supportive. Patient kept asking, "You *have* done this before??" in a quavering voice. Poor man, I spent some time with him afterwards to let him know I appreciated his letting me do my stuff.

Main difficulty is tension of having *nothing* come naturally — all the floor procedures are done differently from what I remembered — charts, meds, CSS equipment, IV etc. The whole works need to be thought out before action taken. Exhausting. And can only improve with time. I think that's what's so enervating.

DIARY of a Retread

So much of nursing is reflex, common sense and rationale — the first is impossible at the moment, and the third I'm struggling to broaden. Thank goodness I have enough common sense to get by, or I'd give up.

Wednesday
Felt quite good today — not as jumpy. I find myself admiring the other women in the group — lots of concern and honest caring for the patient, and still that irrepressible hilarity that surfaces so easily and that I remember so well from former days. It's not all nervous relief either — though that does play a part — *there is real enjoyment of life here.*

Had a clinic on IV therapy — wow. A far cry from what we were allowed to do at school. No IV team here. But I still feel that a lot of the mystique around taking blood is just that — mystique. Seems quite straightforward — as long as the veins are good! Maybe I'll try sometime during the course if I find a likely candidate for experimentation. But my feeling is that an IV team must cut down on the number of phlebitis problems. Can't tell me that *every* nurse is equally conscientious about technique.

Overall personal feelings good today.

Thursday
Class day. Did shock rationale and cardiac and respiratory resuscitation. Doesn't terrify me once it gets going, but the initial moments must be wild.

Saturday
Spent 4 hours at library — did C.V.Dacum plus finishing up odds and ends of neoplasms and trauma. C.V. didn't seem so hard, really, maybe because I've been attacking that programmed fluid and electrolyte balance book for the last few nights in bed. Some bedside reading!

Sunday
Worked at home doing pharmacology Dacum — really finding it hard slogging because so much of it is straight memorization. No chance to put common sense and accumulated knowledge to work. Find that after a couple of hours things begin to slide together in my head and it's game over.

3rd week
Monday
S. tackled fluid and electrolyte balance this a.m. Tackled is the word too — poor woman went at it like a charging lion. Maybe like the rest of us mortals she finds it tough going, though it's hard to find a chink in her theoretical armour — one smart cookie.

In p.m. to hospital again to pick patients for tomorrow. This is my last stint of clinical days on surgery, so tried a patient who will have surgery tomorrow — removal of a ganglion from wrist. Wanted abdominal surgery, since that's the kind I remember best and should upset me least, but this was my next best bet. Talked with Mrs. G. (patient) about the operation, anesthetic, feelings etc. and really found it rewarding. Obviously she needed somebody to talk to and that's the one thing I really feel adequate about in this whole enterprise — being able to draw out someone's basic feelings in order to help her deal with them. Think I did a good job. Now if I can cope with the OR!

Tuesday
Where to start? Made a fool of myself by coming within an inch of keeling over on the sterile field. Didn't even do that as a student! Don't really know what set me off — maybe all the poking and prodding around in a small area full of tendons and nerves and so forth. Gradually got dizzy and uncomfortable; walked out of the room just in case and lay on a bench. Craziness — I was lying there with my head hanging over one end of this dumb bench and my feet over the other thinking through the haze "Oh yes — symptoms of shock: dizziness, vertigo, diaphoresis, rapid pulse.. It's all here... too bad I don't have a BP cuff." Maybe some of the lectures are soaking in after all! Fortunately I felt better soon enough to go back in, help get Mrs. G. onto a stretcher and off to the recovery room. Now *there's* an interesting place. Action, movement, need for theoretical knowledge, patient reassurance, the whole bit. And the whole thing in one big room is my kind of deal too — instant accessibility to everything and everyone. I liked it. Great to be able to be there with Mrs. G. as she woke up; took her back to her room and did her reentry stuff. Good feeling of accomplishment.

Wednesday
Last day on surgery. Was fun to be able to answer Mrs. G.'s questions re her operation from first-hand knowledge. She enjoyed it too, and got a bang out of my fainting nonsense. Complimented me, besides, believe it or not: "You'll get a job — you're a great nurse." Wonder if I can use patient testimonials on my rounds of pounding on doors of hospital personnel offices??

Hard to move on to the next area — we're all a bit nervous again. Having been used to B.'s "supportive nitpicking," what will D. be like? Funny — the other group is feeling the same about B! We're busily reassuring each other like a gang of first-graders. No matter how secure we are in our own lives, new roads are always a bit scary. Though some manage to camouflage it more than others.

Thursday
Class day. Don't know what it was, but we didn't swing as a group today. Discussion seemed draggy. Not stretching our minds as much. Did M.I., C.H.F. etc. Found myself personally involved in the discussion because of Butch's heart attack. Really two years ago? We seem to have lived with that forever — so lucky to have a crack at restructuring lives, priorities etc. That's something I have to share with my patients and their families — a way of looking at a blow like that that isn't necessarily devastating. Those who survive have a very special chance to rethink their lives — in all dimensions. It's not to be sneezed at as a growing experience.

Had my mid-term discussion with B. Fair shake, I think. Comforting to discover that the area she thinks I need work in — technical skills — is exactly where *I* think I do — nice to have one's self-evaluation reinforced. (Other areas — knowledge and attitude — are OK.) Maybe this was a good idea after all.

4th week
Monday
Did my thing at the library over the weekend. That is getting to be quite a comfortable routine now: shove the kids out the door Friday a.m., be at Steinberg's to do the grocery shopping at nine sharp, out by 9:20 and sitting in the library by 9:40. Then I can get my list of books prepared, and have about an hour to start on the Dacum for next week before I have to get home for the kids' lunch. And things are set for Sunday studying all p.m. Unfortunately, Friday p.m. has to be reserved for making some headway into the week's accumulation of dirt in the

house. Butch is being a pet about doing more than his share of the housework, but I feel a bit guilty if I can't at least get things started before the weekend. He says that's silly, but I can't help it. Maybe I'm the sexist in this family — no matter that we're both loaded with out-of-house responsibilities at the moment — I still have that niggling feeling that basically the house is my responsibility. Dumb, dumb.

Anyway, it was a quiet day at school — mostly talking and watching films on how to communicate with patients. Did a few communication exercises, too. So difficult to teach that sort of thing. I feel the vital thing is to have an ability to very quickly assess the patient's mood and needs on first contact and then react accordingly. No point in soft answers to the man who wants a good argument in order to clear the air before he gets his real feelings out. Equally no point in coming in all breezy and cheerful to a patient who is shy and/or depressed and needs a quiet, gentle approach with a minimum of bustling about. Maybe that's one advantage that comes with the curse of being shy — an ability to gauge vibrations pretty accurately. Could be an advantage for all of us because of our ages — more time and life experience under our belts.

In the p.m. we met in the hospital lobby again to head off with D. to our new ward which is completely different — don't know whether every ward is a law unto itself or whether those were just chosen as a deliberate attempt to expose us to totally divergent areas. In any case, it's weird. The nursing station has about half the room behind it as the average rec room bar and twice the number of people around it. Charts everywhere but in the cart; narcotic cupboard in a utility room; med cupboard — unlocked — in a sort of converted linen closet down one hall; back rub materials in a closet clearly marked "IV equipment" ... a strange place entirely. Also a completely different aura somehow — the nurses seem to be mostly floats, so many students, interns, etc. that a feeling of oneness of purpose is hard to grasp. My patient for tomorrow is an 87-year-old lady with seizures and pneumonia, from a nursing home somewhere. We'll see how that goes.

Tuesday

Well, I made it. But barely. It was rather fun doing little Mrs. K. — she's tiny and determined and wanders in and out of reality like a kid in a revolving door, but I must admit I didn't really feel as if I learned a heck of a lot. I was so worried she'd zing out of her bed onto the floor and cream herself that I couldn't concentrate on exploring the ward, reading charts, procedures or whatever. A good day of patient care, since I did do a good day's work for her, but nothing really *learned*.

In the p.m. we had a lecture on various kinds of O_2 therapy equipment. That brings up another interesting point of hospital priorities. O_2 therapists (inhalation therapists, really) are on 24 hours a day, which would mean a substantial staff, I presume, and nurses are not required to do anything really, except see that the patient has the mask or cannula or whatever *on*. The therapists do the whole shot — set up the liter flow, fill bubblers and so forth. And yet, every nurse is required to learn to start I.V.s, take blood etc. No I.V. team — too expensive. But which actually costs more, and which really *needs* the expert and conscientious care of a select group?? Seems to me the average patient would be in a whole lot more danger from procedures involving the blood stream than from procedures involving O_2. We're all taught how to administer O_2 and it isn't that involved — just a matter of becoming accustomed to the different equipment. Maybe I'll see the hospital logic as I become more accustomed to the work, but at first exposure, I'm really confused. Not a good day altogether, and my back is beginning to bother me again.

Wednesday

Second day on medicine and a bit better. I removed a Foley catheter from my lady — D. supervised — and managed to wander about a bit more on my own. Helped bandage the stump of an amputated leg and watched the physiotherapist do ultraheat and ultrasound treatments on decubiti. Interesting. Will keep an eye on the sores over the next 2 weeks and see how they react. (Hey, only 2 more weeks!!!) Also learned to take my books into Mrs. K's room so I could study and keep an eye on her at the same time.

In the evening, a bonus for me. A seminar at our church on death and dying — how to explore our own feelings in order to help others. We filled out a

ACTIFED*

Tablets/Syrup

Triprolidine HCl/Pseudoephedrine HCl

Antihistamine/Decongestant

Indications: The prophylaxis and treatment of symptoms associated with the common cold, acute and subacute sinusitis, acute eustachian salpingitis, serous otitis media with eustachian tube congestion, aerotitis media, croup and similar lower respiratory tract diseases; in allergic conditions which respond to antihistamines including hay fever, pollenosis, allergic and vasomotor rhinitis, allergic asthma.

Precautions: Use with caution in hypertensive patients and in patients receiving MAO inhibitors. Patients should be cautioned not to operate vehicles or hazardous machinery until their response to the drug has been determined. Since the depressant effects of antihistamines are additive to those of other drugs affecting the central nervous system, patients should be cautioned against drinking alcoholic beverages or taking hypnotics, sedatives, psychotherapeutic agents or other drugs with CNS depressant effects during antihistaminic therapy. Rarely, prolonged therapy with antihistamines can produce blood dyscrasias.

Adverse Effects: None serious. Some patients may exhibit mild sedation or mild stimulation.

Dosage: Adults & children over 6 years, 2 teaspoonfuls of syrup or 1 tablet 3 times daily. Children 4 months to 6 years, 1/2 adult dose. Infants up to 4 months, 1/2 teaspoonful of syrup 3 times daily.

Supplied: Syrup, Tablets: Each white, biconvex tablet 7.4 mm in diameter with code number WELLCOME M2A on same side as diagonal score mark or each 10 ml of clear, lemon-yellow syrup contains triprolidine HCl 2.5 mg and pseudoephedrine HCl 60 mg.

The syrup is available in 115, 225 and 2250 ml bottles; tablets are available in packages of 12 and 24, and bottles of 100 and 500.

Burroughs Wellcome Ltd.
LaSalle, Que.

*Trade Mark W 4051

DIARY OF AN OBITUARY

questionnaire on how we feel about our own death, or the death of someone else, and discussed quite freely — it was a good experience. A common feeling was that one would want to know *oneself* about a terminal illness, but would hesitate to tell the family because then there is the added pressure of having to deal with the other person's sorrow as well. It is *essential* to be honest, in my book — when there is only a limited time left, who wants to play games? A good seminar.

Thursday
SNOWSTORM. Wow. Today, M. gave us a test on stress and we discussed liver problems and a bit on peptic ulcers, though everyone was anxious to get home and deal with snow and tires and kids' boots and piled-high walks and so forth. I guess liver pathology — or even normal physiology — is something that most of us haven't really studied very much—or been exposed to in patient care. Certainly I'll have to do a lot of brushup in that area. I find it hard to get a handle on M. — not sure why. She's certainly competent and concerned — but presents such an even surface that it's difficult to feel where she is at personally. Funny how I find myself analyzing the teachers — unfair too — although they're likely doing the same thing to me! But interesting that I'd bother to try — I can't remember thinking terribly deeply about teachers in my student days. They were either good or not so good; fair or biased; able to see beyond the masks or not. I don't remember caring one way or another what kind of *persons* they were. And I do now. Maybe it's a function of growing up — or maybe having discovered that teaching is never 'value-free' — *nothing* is value-free. There's always the person doing the teaching coming through.

5th week

Monday
Someone in to talk about respiratory problems. Knows his stuff but, today at least, had a bad time getting it across. In p.m. it was back to wards. I asked D. to assign me to someone who didn't have to be physically lugged around and she did, bless her. Mr. F., a recovering M.I. Fell into bed at night, back screaming. Rotten day.

Tuesday
My patient was light work, physically, since he can be up, so I ended up making beds and bathing and helping with other patients. Still have the "service" orientation in me — I could have studied my patient's problem and not assisted with the ward work, but really can't do that. And I don't feel I should, either. Nursing is such an odd mixture — educated we may be, but our first duty is service, and I hope it stays that way.

Worked on nursing care plan. Am gradually coming to terms with those things. Still feel they're a bit padded with stuff that could remain unsaid and understood, but maybe it helps to put things down in black and white. Who knows?

Wednesday
Spent much of the day talking with Mr. F. about diet, exercise, health care at home and so forth. Felt I did a good job too. He was very cooperative — wanted so much to know how to keep from getting sick again — and I think I helped a fair bit. I told him what to notify the doctor about without unduly panicking him, I think, and feel I did a good job. Nice feeling to have.

Thursday
End of our 5th week. Can't believe it. And still don't feel at home on the medical floor. Is it a slump or what?

Class day again. Respiratory guy back with a much better presentation. This time got personally involved with his subject and swung a lot better. Interesting views on I.P.P.B. that we were all so in awe of! A much better time and I'm beginning at last to see the end of the tunnel re acid-base balance. Hallelujah!

After work, went over to new hospital to update my application and try for the geriatric ward, opening in January.

Friday
Last Dacum — diabetes. And as I suspected, my worst pretest to date. I really have to spend the whole weekend sorting out diabetes.

Sunday
Did up diabetes Dacum reasonably quickly on weekend — more came back as I studied than I'd anticipated. Guess it is because diabetes is rather an entity in itself.

6th week

Monday
Went over diabetes pretest. Covered a good deal of ground. Two members of the group have both done a lot of nursing of diabetics and had lots of helpful hints for the rest of us. I continue to be amazed and delighted at the depth and breadth of the personal and professional experience of the class — particularly in the eight I've worked with more closely. The insights they have are quite remarkable in *any* group of women.

Tuesday and Wednesday
Doctor said I should spend some time on my back to rest it — apparently it's a disc problem. Asked D. if I could skip Tuesday's ward day and see if 24 hours in bed would help. Hated to do it, but seemed the best idea. Called back to say both she and B. felt I could and should stay home Wednesday too — apparently the evaluations are already made out. Am going to try to make it for Thursday, to finish up the diabetes theory and get in on the general course evaluation. Dying to hear what some of the other women feel about the course in general, how they would improve it; and also how S. felt about our general performance. If I can crawl, I'll make it!

Thursday
Fast summary — it's been worth it! I've grown a lot, I've learned a lot. I have a generally good opinion of my nursing colleagues. I feel the instruction has been excellent and the study approach fantastic. Family has survived basically well. Husband has been supportive beyond hopes. Now— to get a job!

Heather Nelson (R.N., Kingston General Hospital) is now employed at the Neonatal Intensive Care Unit at the Children's Hospital of Eastern Ontario in Ottawa. She was a staff nurse at the Neonatal Intensive Care Unit at Kingston General Hospital until 1968, when she left to raise her two children. After seven years, she decided to go back to nursing. She says of her decision to take the refresher course: "I entered it because I thought, with the tight labor market, I'd never get a job otherwise after being away for seven years . . . but as I progressed I found the benefits much more far-reaching than merely job preparation. It was great to study again, to test myself in new situations and to find my self-confidence increasing almost daily. I am better prepared for work now and, of equal importance, am also prepared for further personal development."

DILEMMA

In the past five years, 577 families have undergone amniocentesis through the Prenatal Genetic Clinic in Toronto to test for genetic disorders of their unborn child. Of these families, five percent have been confronted with selective abortion as a result of prenatal genetic testing. There is no precedent to help them cope with the dilemma they must face....

Prenatal genetic testing of a developing baby during the first half of pregnancy is a relatively new approach in dealing with serious genetic disorders. Given the diagnostic procedures to determine genetic disorders and chromosome abnormalities before birth, the health team and prospective parents alike are confronted with new questions and responsibilities.

Since 1971, a testing service has been available in Toronto to evaluate and support couples when the risk of having a deformed child is evident. A team comprised of a geneticist, an obstetrician, a radiologist, a biochemist, a cytogeneticist, and a nurse are involved in the care of each couple. Similar genetic counseling facilities are found in most large university centers in Canada.*

Prenatal Diagnosis

At present, certain chromosome disorders, biochemical diseases, X-linked conditions, and open neural tube defects are being detected through prenatal testing. It has been determined that some couples have a greater risk of bearing a child with such disorders. Factors indicating that tests for these diseases in the fetus should be considered are listed in Figure 1 .

If couples have had a previous stillbirth, a child with multiple malformations, spina bifida, Down's syndrome (mongolism), mental retardation, or a biochemical defect, they should receive genetic counselling before another pregnancy to discuss the risks of recurrence of such defects and the value of prenatal testing if another pregnancy is being considered. Many types of birth defects cannot be diagnosed by the available prenatal testing techniques and the families involved must then accept the risk of recurring defects with out the aid of prenatal testing.

Evaluation of the fetus in the first half of pregnancy can be done through amniocentesis and ultrasonography. Fetoscopy is in the developmental stage as a prenatal diagnostic device. (These tests are examined in Table 1).

The Nurse and the Patient

The role of the nurse as a prenatal genetic team member has evolved as the clinic has developed. Information gained through close contact with couples over a period of time has brought the unique needs of these couples to light, and has helped the health team to deal with their needs more effectively than was initially possible.

The nurse has the opportunity to assess the needs of the patient as they are expressed at the clinic, to support the patient and help to alleviate anxiety, and to communicate the patient's needs as

Figure 1

Factors Indicating Prenatal Genetic Testing

1. Chromosome Disease

a) Maternal age — The risk of Down's syndrome increases from 1:2000 live births at maternal age 20 to 1:300 at 35 and 1:100 at age 40.

b) Parental chromosome abnormality — If one parent has been identified (through family studies or the birth of an abnormal baby) to be a carrier of a chromosome rearrangement, all subsequent pregnancies should be monitored by amniocentesis.

c) Previous trisomy — If a previous pregnancy had terminated in a conceptus with trisomy (Down's syndrome) — whether livebirth, stillbirth, or spontaneous abortion, — subsequent pregnancies should be monitored.

d) Anxiety — If the parents are unduly anxious concerning the possibility of abnormality of the child, this is not necessarily an indication for testing. In this case, each couple is treated individually.

2. Biochemical Disease

Generally, parents are proven carriers of biochemical disease as an indication for testing. There are now 80 different inborn errors of metabolism that can be tested in utero by showing enzyme deficiency in cultured amniotic fluid cells.

3. X-linked Conditions Not Detectable in Utero

Certain inherited diseases affect the male child of a known female carrier. In cases where the condition itself cannot be determined, sex determination through amniocentesis is valuable eg. Duchenne muscular dystrophy affects 50 percent of the male offspring of a known female carrier.

4. Open Neural Tube Defects

Previous birth of a child with an open neural tube defect indicates a five percent risk of recurring disease. Amniocentesis is done for determination of alphafetoprotein levels (an elevation in alphafetoprotein indicates the presence of an open neural tube defect).

** These indications for prenatal testing are extracted from the Canadian guidelines for antenatal diagnosis of genetic disease as published in 1974.*

** A list of medical genetic centers in Canada is available on request from the C.N.A. Library.*

she sees them to other team members, so that support can be given in an aware and consistent way.

Couples are referred to prenatal clinic by their own doctors. At the clinic, they are interviewed by a geneticist who discusses with them their risk of having a child with a genetic defect and explains to them the limitations of prenatal diagnosis. Each patient is also examined and interviewed by an obstetrician in order to set the dates for testing. He also discusses the risk of abortion caused by amniocentesis, a risk of less than one percent. It is after these interviews that the nurse first meets the patient.

Many patients express their confusion to the nurse when they first visit the prenatal clinic. Their questions imply uneasiness in a situation that they have not faced before. Initially, the patient may ask questions about the clinic itself, about the number of health personnel that they are required to see, the necessity for a number of visits, or the role of their own doctor in their care.

The nurse may find it helpful at this time to explain the consulting nature of the team — that the team works together in the patient's interest. She lets the patient know that her family doctor will be kept informed by the team and will continue her care after testing is completed. The nurse conveys her personal interest in the patient and asks if she may telephone the patient as she progresses through her pregnancy.

One of the main concerns expressed by the patient during the initial interview with the nurse involves the procedure of amniocentesis itself. Fears of what will happen to them or to the baby during the test can sometimes be alleviated by a thorough and understanding explanation of the procedure and its preparatory routines. It is often helpful for the nurse to relate the reactions of other patients to the test, and if further support seems necessary, women who have previously undergone amniocentesis may be called upon to reinforce the nurse's supportive explanations. Several women who have had this test have volunteered to talk to anxious patients.

Another early concern of the patient is with the risk of abortion as a result of testing. Such a risk has been pointed out to the patient by both the geneticist and the obstetrician in the first meeting. Women may wonder if such a risk factor makes testing advisable although they are also concerned about having an abnormal child. Questions that the patient may raise are a good indication of her understanding of what she has been told by members of the team and of her emotional needs. If the patient misunderstands genetic risk factors, such information may be communicated to the geneticist or obstetrician so that the team can work together in clarifying her questions.

The initial nurse-patient interview allows the nurse to assess the patient's psychological needs and her understanding of genetic disease and prenatal diagnostic testing. It also serves as the beginning of a relationship to continue throughout the woman's visits to the clinic.

The Waiting Period

Following ultrasound and amniocentesis, the nurse visits the patient for a second time. Many patients express relief that the testing is over, and most confess that it wasn't as bad as they had anticipated. Some find the ultrasound "fascinating" to watch. Others are disappointed because they slept through the test.

Perhaps the greatest worry expressed by the patient at this time concerns the chance of aborting as a result of the testing. She may ask what she is to expect if she aborts, whether she should moderate her activity, or how long the risk of spontaneous abortion will be present. It is explained that "abortion dangers" are considered to extend to two weeks following the testing, and that the patient should contact her family doctor if she does have any physical concerns.

Patients must wait a minimum of three weeks for the results of the tests and the wait may be an anxious one. Women may feel very hesitant about their ability to make the decision to abort a defective fetus. Some hint at this time that they haven't told anyone about their pregnancy and don't plan to until they receive test results. Others state more directly that they'll need help if they receive test results indicating that an abortion should be considered. Questions about where the abortion would be done provide other hints about this concern. The nurse ought to be aware of the worried implications of these questions and statements. She tells the patient that both she and her family doctor will be notified as soon as the test results are known, and that any steps necessitated by the results will be taken with the full support of the team.

Women may or may not wish to be told of the sex of their child. The geneticist of the team is kept informed of the patient's wishes.

The patient at this time may be able to express some of her feelings to the nurse. Her concerns about having a handicapped child, or her reactions and those of her family to her pregnancy may be voiced as her relationship with the nurse proceeds. She may feel she has to explain why she came for the testing, and it is important for her to have someone to talk to about her feelings concerning the whole experience.

Testing is performed on an out-patient basis. Several days after the procedure, the nurse phones the patient to see how she is feeling. This call enables the patient once again to express her feelings and any anxieties she may have over the three week waiting period. The nurse reminds the patient to call her own doctor if she has any unusual symptoms. The patient is also given the nurse's phone number so that she may call if test results have not been reported to her in three weeks. If test results are normal, the last contact the nurse has with the patient is after the birth of her baby.

Implications of Prenatal Testing

Amniocentesis for prenatal diagnosis of genetic disease has recently become an accepted approach for families who face a high risk of bearing a child with a serious genetic disorder. In the past five years, 577 families have had an amniocentesis for genetic indications through the Prenatal Genetic Clinic in Toronto. The majority of these couples received good results and assurance that their baby was free of the genetic disorder in question, but some did not. Twenty-seven women decided to terminate their pregnancy prior to 20 weeks gestation as a result of information received through prenatal genetic testing. Very little has been written to date about the new dilemmas we are creating for such couples. Our close contact with these 27 couples has given us insight into the unique needs created by a difficult

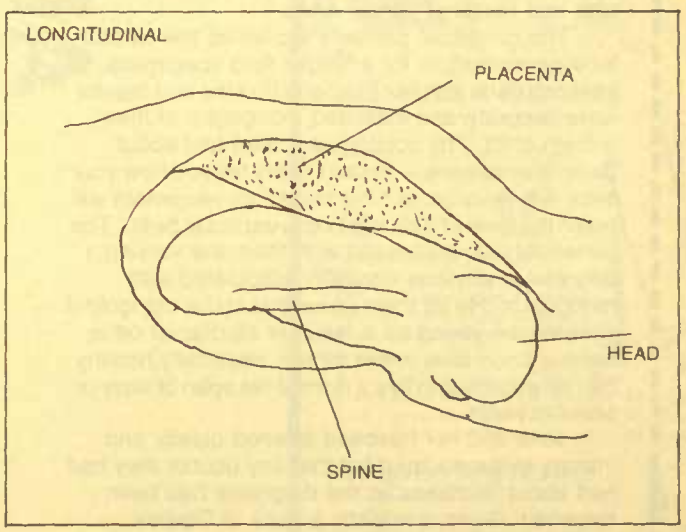
Table I

Test	Time	Method	Analysis	Results
1. Amniocentesis	— 16th week of pregnancy when i— fundus above pelvic brim ii— fetal cells present in amniotic fluid	— local anesthesia — needle puncture through abdominal wall — 10 to 15 ccs of amniotic fluid aspirated by needle from the amniotic sac	— cells in amniotic fluid cultured for chromosome and biochemical analysis — cell-free fluid analyzed for alphafetoprotein (a protein manufactured in the fetal liver)	— indication of biochemical or chromosomal abnormality — elevation in alphafetoprotein indicates the probability of an open neural tube defect (spina bifida, anacephaly) in the fetus
2. Ultrasonography	— just prior to amniocentesis	— sound waves used to generate picture (like the use of sonar to detect underwater objects)	— picture indicates: i— localization of the placenta ii— presence of twins iii— configuration and growth rate of the fetal head iv — ventricular system of the brain v— fetal kidneys vi — the emptying and filling of the fetal bladder	— allows for increase in knowledge of normal fetal development — guides needle placement for amniocentesis by showing position of the placenta — allows for evaluation of the fetal skull and spine (open neural tube defect)
3. Fetoscopy	— not yet done routinely — still in developmental stage as a diagnostic device	— local anesthesia — scope inserted through anterior abdominal wall to scan the fetus and sample tissues or blood	— allows direct visualization of the fetus (total fetal visualization not always guaranteed) — abortion rate unknown at present	— potential (not yet fully established) to diagnose a number of anomalies

Ultrasound photos and line drawings: Fetus at 25 weeks

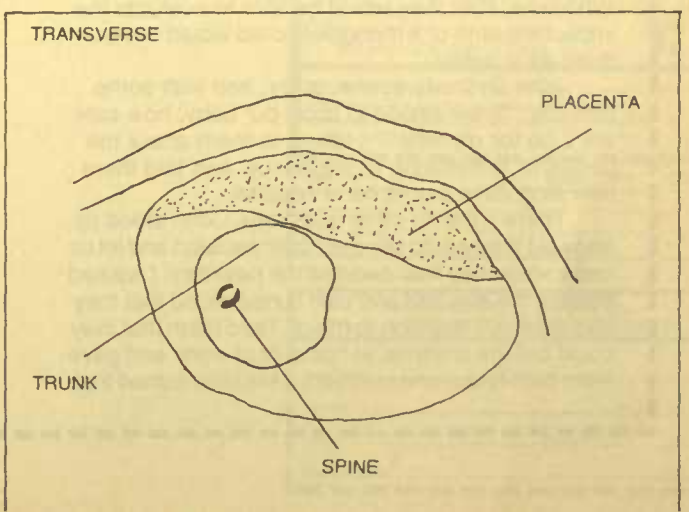
A





B





Case Study

In her sixteenth week of pregnancy, 40 year old Jane D. was tested through amniocentesis for the presence of genetic disease in her unborn child. Three weeks later, test results indicated that Jane was carrying a child with Down's syndrome or mongolism. She and her husband John were contacted by their family doctor, who broke the news to them. He also told the couple that the amniocentesis team would be available on the following day to discuss the alternatives available to them.

We were seated in lounge chairs in the hospital conference room — the geneticist, Mr. and Mrs. D., and myself, the amniocentesis nurse. Jane D. and I smiled at each other in recognition — we had talked together at antenatal clinic, and on the day of her amniocentesis. She looked fairly composed, and I wondered how she managed after what must have been an anxious and sleepless night.

Jane was the first to speak and break the silence — "I really can't believe this is happening to us. Our doctor says something's wrong with our baby. Couldn't there be a mistake somewhere? How do we know that the test results are right?" The shock and denial in her voice was something I'd seen in others who had received similar news.

The geneticist patiently explained the careful labeling procedure for amniotic fluid specimens, assuring Jane and her husband that the test results were accurate and indicated mongolism in their unborn child. The couple were then told about Down's syndrome — "I can't really tell you how your baby will develop, but his mental development will reach the level of a six or seven year old at best." The geneticist also discussed with them the varying degrees of physical disability associated with mongolism. He let them know that some mongoloid children die young as a result of cardiac or other serious anomalies, while others, physically healthy can be expected to live a normal life span of sixty or seventy years.

Jane and her husband listened quietly and intently to the doctor. I felt that any doubts they had had about 'mistakes' in the diagnosis had been dispelled. Given a realistic picture of Down's syndrome, I felt they would be able to evaluate the impact the birth of a mongoloid child would have on them as a family.

John D. finally spoke, softly, and with some difficulty: "If we decide to abort our baby, how safe will it be for my wife?" I talked to them about the details of terminating a pregnancy, and told them how long Jane would be in hospital.

There were no other questions. John stood up, and said they would talk over their decision and let us know what they had decided the next day. I walked them to the elevator and said I understood that they had a difficult decision to make. I told them that they could call me anytime, at home or at work, and gave them both telephone numbers. I also mentioned that other couples who had faced a similar decision could talk to them if they thought it would help.

The next day, Jane phoned and told me that she and her husband had decided to terminate the pregnancy. She asked that it be done as soon as possible. I made an appointment for her with the obstetrician on the team, who would reexamine her before she came into the hospital and explain the procedure to her. I told Jane the date and time of her admission to hospital, and said I'd visit her soon after her arrival.

Then I spoke to the head nurse in charge of the floor to which Jane would be admitted, discussing with her the circumstances of Jane's abortion. This let the staff know that Jane was being cared for by the amniocentesis team, and that she would have need of their support.

Soon after Jane's admission I went to see her. I found her sitting on the edge of the bed with her back to the patient next to her. I thought that she wanted privacy, so I suggested that we go for a walk. Jane immediately expressed how difficult it had been for herself and her husband to make the choice and said she felt "like a murderer." I told her that the way she felt had been expressed by others with the same concern, and encouraged her to talk about her feelings. Together we discussed her choice, and Jane described in detail how she and John had reached their decision. The abortion had been booked for the following day, and I told her that I'd see her beforehand.

Jane looked frightened and somewhat tearful when I saw her early the next morning, and said she was really "anxious to get it over with." I went with her to the floor where she was to receive the saline injection. After the injection, I spent the afternoon sitting with Jane at her bedside until her husband arrived. We talked about everything from politics to religion. Now and then she would ask when I thought the labor pains would start. That evening I phoned Jane from my home.

The next morning when I went to see Jane, she was up walking in the halls. She appeared to be relatively relaxed. She told me that she had aborted at about four in the morning, and compared the physical experience to that of giving birth, saying it was more intense but took a shorter time than her other deliveries had taken. Jane was anxious to go home, and talked of "getting out ... as soon as the doctor comes in."

I visited Jane in her home three weeks after the abortion. She said that the whole experience already seemed slightly unreal, but that she was troubled by recurring dreams about it. She seemed relieved to know that other women had reported such dreams, but that the dreams had been only temporary in nature. Jane also said that she felt closer to her three children than she had before the abortion.

I still keep in touch with Jane periodically — she tells me that time has helped her to see the experience in a different perspective and to incorporate it into her life.

choice. Because prenatal diagnosis is a relatively new approach with implications for future management of genetic disease, we wish to share this insight.

Abortion

It is during the initial interview in the Prenatal Genetic Clinic (before testing) that the issue of abortion is raised by the doctor to give the couple a chance to express their feelings and air their differences. Some couples express practical concerns and are able to evaluate their situation realistically and positively. They may state: "We just couldn't afford to have another child with Down's syndrome."

Many couples however, do not see abortion as the inevitable outcome of test results that indicate an abnormality, and they need to work out their feelings to determine if such a route is justified. This ambivalence may be seen in 'selfless' comments, like "I could handle it but my husband couldn't," "It wouldn't be fair to our other children," or "I wouldn't want to inflict such a hard life on the child."

All these feelings and attitudes should be explored and documented in an interview before testing in the event that test results should prove abnormal. If a decision is to be made in favor of abortion, it must be made within a short time after the results are known, so it is important that the couple understand their feelings and have the time to consider their decision. It is also helpful to health personnel to understand how the couple feels, so that they can better support them in their decision.

When an affected fetus is diagnosed, the patients are told of results of tests by the doctor best acquainted with their needs, perhaps by their family physician. They may also require a pre-admission interview with the geneticist and nurse to discuss the implications of the test results and the method of termination of the pregnancy.

Women admitted to hospital for an abortion of an abnormal fetus may express many conflicting feelings about the unborn child and about the decision they have made to abort. At this stage of pregnancy, they are able to feel the movement of their baby, and this may compound their feelings of guilt and confusion. "I can feel the baby kicking — it would be easier to terminate if I hadn't felt life." Questions about the abortion procedure itself, or about what will happen to the baby are common.

Many patients relate the difficulties they have had in dealing with another handicapped child in the family. Others with healthy children may tell about their family's happy activities and of their concern about allowing this happiness to be interrupted by the birth of an abnormal baby. They attempt to justify their decision and to communicate their need for understanding. Often they cry when they talk of their families or their other children.

Concern about 'what others will think' is also evident. A number of patients have not yet told anyone of their pregnancy, and will tell the nurse of excuses they have given family and friends for their hospitalization. Those who have shared their pregnancy with others may feel a great deal of social pressure when they decide to terminate. Acceptance by hospital staff is most important and helps to alleviate the painful effects of an unhappy decision on the part of the patient. A number of patients have been visibly upset by comments from nurses whose lack of understanding brought questions like "Did ▷

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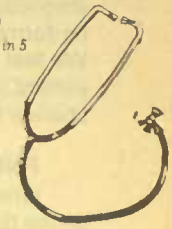


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Follow-up

When the Clinic began, many women raised issues during the immediate recovery period, which we were not prepared to deal with. We now make a point of discussing such issues with families before the abortion if they are not initiated by the patient. They raised such questions as, "Can I see the baby?", "Where will it go after you have done your studies?", "Can we arrange a burial?", "Will I know the results of your studies?". How these questions are answered varies with each patient. If studies prove valuable for management of a future pregnancy, then the family should be informed. This decision is reached before the abortion so everyone knows how to handle the family's questions.

One woman has reported recurrent nightmares about the baby after two years post-termination. Another woman, also in the advanced maternal age group, had vivid dreams about her baby at the expected date of confinement after the abortion. Although all the women who chose to have an abortion insisted that they had no regrets about that decision, many were still having difficulty dealing with the fact that they had produced an abnormal baby. One woman, when asked if we could have made things easier for her stated that she wished she had never looked at the ultrasound photo because seeing the fetal head made the baby more real to her and created difficulties for her when she decided to have an abortion.

After the initial follow-up care by telephone or home visiting from our amniocentesis nurse, several families required a visit from the geneticist to help answer some of their questions about the baby. At this interview, results of post mortem studies were given (if they were previously decided upon) and the implications of these studies for other family members or themselves were discussed. Our impression was that these interviews were regarded by the family as a completion of an unhappy event. After the interview they felt better prepared to put the event in perspective.

In summary we feel that the unlucky five percent of families who face selective abortion as a result of genetic amniocentesis are a unique group of people in our society. There is no precedent to help them cope with the ordeal they must face. They require a fair amount of professional time before, during, and after the therapeutic abortion to help them work through many of the conflicts, questions, and anxieties which arise. Those of us who generate these anxieties should assume the responsibility of spending the necessary time with these families and ensuring that adequate support is available for couples. In addition, support can be forthcoming through their family, church, other couples who have been through the experience, and a nurse who has been with them throughout the experience. In this way, we may lessen the long-term psychological complications of this new sociological dilemma which scientific advance has created.

Noreen L. Rudd, (M.D., F.R.C.P.(C)) is a graduate of the University of British Columbia. She is presently a Staff Geneticist and Pediatrician at the Genetics Department, Hospital for Sick Children, Toronto. She is also an Assistant Professor of the Departments of Medical Genetics and Pediatrics at the University of Toronto.

Betty M. Youson, (R.N., B.N.) is a graduate of the Hospital for Sick Children in Toronto and McGill University in Montreal. She has had previous experience in public health nursing, nursing education and as a research assistant. Youson is presently on staff at the Genetics Department, Hospital for Sick Children, Toronto.

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Names and Faces

The University of New Brunswick acclaimed **Margaret G. McPhedran** (R.N., Charlotte E. Englehart Hospital, Petrolia, Ontario; B.A., University of Toronto; M.A., Columbia University, New York), by making her honorary professor emerita at Encaenia exercises in Fredericton, on May 13, 1976.



Professor McPhedran has been associated with the University of New Brunswick's nursing faculty from its beginning in 1959 until her retirement in 1974. She served as acting director of the school in 1962 and was appointed dean when it was made a faculty in 1968.

Professor McPhedran's career has included 16 years' service to UNB as teacher and administrator and previous positions as instructor of nursing at the Metropolitan School of Nursing, Windsor, and assistant professor of the School of Nursing, University of Toronto.

Janet Chatterson (R.N., St. Giles Hospital, London, England and Toronto East General Hospital; B.Sc.N., University of Windsor) has been appointed National Coordinator of Health and Community Services of the Canadian Red Cross Society.

On joining the Canadian Red Cross Society in 1973, she was Assistant National Director of Family Health and served as Acting National Director prior to her present appointment.

She has previously taught at the Toronto East General Hospital School of Nursing and was a Canadian Red Cross Observer in the Guatemalan earthquake zone.

Nessa Leckie, (R.N., St. Paul's Hospital, Saskatoon, Sask.; B.N., McGill University, Montreal, Quebec) director of nursing, Douglas Hospital, Verdun, Quebec, retired on April 30 after seven years in the post. Formerly assistant director in charge of nursing education, Leckie joined the hospital staff in 1958 as an instructor.

Leckie has been involved in nursing education programs in three large mental hospitals. She did clinical post-graduate work at the Alberta Provincial Mental Hospital at Ponoka. While at Douglas Hospital, she was chosen a member of the Canadian government external aid mental health advisory team, and was sent to the Caribbean in 1966 for a year. There she helped reorganize the nursing education at St. Ann's Hospital, Port-of-Spain, Trinidad.

Hélène Berthelot replaces Leckie as the director of nursing at Douglas Hospital. Berthelot received her basic nursing education at L'hôpital Saint-Sacrement in Quebec; her post-graduate training in child psychiatry at L'hôpital Sainte Justine; and her M.A. in nursing at the University of Montreal. She has been at Douglas Hospital since 1972.

Carolyn Marie Pereyma of Sedley, Saskatchewan has been awarded the Kathleen Ellis Prize for the most distinguished graduate in the College of Nursing at the University of Saskatchewan's 65th annual spring convocation on May 20, 1976.



Max Hugel (R.N., Brockville Psychiatric Hospital School of Nursing; B.Sc.N., University of Ottawa) has been appointed Director of Nursing at Brockville Psychiatric Hospital, Brockville, Ontario. Hugel's psychiatric nursing experience includes general staff nursing, area supervisor, nursing coordinator and acting assistant director of nursing at Brockville Psychiatric Hospital. He has been involved in the hospital's Planning Committee and is also the author of a Psychiatric Nursing Program which is to be implemented in the hospital's Psychiatric Unit. The program focuses on an intense ongoing nurse-patient relationship which will allow the patient input into his/her type of care.

The following are new appointments to Lakeshore Psychiatric Hospital, Toronto:

Vahe Kehyayan (B.Sc.N., American University of Beirut, Lebanon; M.Sc.N., University of Toronto), Clinical Nurse Specialist in Community Health Nursing.

Joan V. Abbott (B.Sc.N., Memorial University of Newfoundland; M.Sc.N., University of Toronto), Clinical Nurse Specialist in mental health and psychiatric nursing.

Grace Darling (B.Sc.N., D.P.H.N., University of Western Ontario, D.P.H.N.A., (M.H.) and B.A., M.Sc.N., University of Toronto), Clinical Nurse Specialist in mental health and psychiatric nursing.

Nora I. Parker, (Ph. D., University of Toronto, Faculty of Nursing) has received a grant from the Ontario Ministry of Health for the development of credit examinations for diploma graduates entering a baccalaureate nursing program. This project is to develop methods of determining the extent to which applicants have mastered the competencies peculiar to baccalaureate education. Examinations will be based on assumptions regarding differences in baccalaureate and diploma education, and the further assumption that competencies to be tested may have been acquired by means other than formal education.



Eva M. Wideman (R.N., B.A.) has recently returned to Canada after a 2-year tour of duty at the Jordan University Hospital in Amman, Jorda with MEDICO, a service of CARE.

Wideman previously nursed at the Royal Alexandra in Edmonton ar at St. Paul's in Vancouver before going to the new 220-bed Jordan University Hospital where, as Education Supervisor, she established the In-Service Educati Department. Her duties included th teaching of medical English and h to write medical charts not only to Jordanian nurses but multinational as well.

This was the first hospital in Jordan to establish an In-Service Education Department which is bei keenly observed by other hospitals

Dorothy Wylie recently joined the RNAO staff as director of its newly organized division on nursing. She leaves her position as Director, Patient Care Services, Sunnybrook Hospital in Toronto.

Eunice Coles (R.N., Hospital for Si Children, Toronto) recently retired Senior Assistant Director of Nursing the Hospital for Sick Children, Toronto, after 32 years of service.

In 1944, Coles returned to wo because of a nursing shortage, worked in the Emergency departme and in the surgical clinic before taki a position in the Nursing Office, whe she remained until retirement.

She has been described by h colleagues as a great humanitaria and a concerned professional abo patient care.



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Research

● Amputation in Children

Adjustive and Affective Responses of School-aged Children to a Leg Amputation. Pittsburgh, Penn., 1975. Thesis (Ph. D. in Pediatric Nursing) University of Pittsburgh by *Judith Anne Ritchie.*

The purpose of this study was to examine the adjustive and affective responses of children undergoing a leg amputation. Five children ranging in age from ten to fourteen years were studied for two to six days preoperatively and six to nine days postoperatively.

The data were collected through unstructured observations and interviews conducted during periods in which the investigator was providing the children's nursing care. The data collection sessions were chosen to coincide with events which were likely to be crises or which would focus the child's attention on the amputation.



The children's hospital experiences were examined in four time phases: the preoperative phase, and the early, middle and late postoperative phases. The behavior protocols were divided into units of behavior measurement and were categorized according to the dimension of the "self as amputee" and the behavioral responses to each of these dimensions. The dimensions of the "self as amputee" include condition of the self, physical characteristics, and social aspects. The behavioral responses include both adjustive and affective responses.

The children's predominant response to the aspects of the "self as amputee" was adjustive behavior through which they began to understand the reality of changes within themselves. Adjustive responses were most frequently in the form of verbal and non-verbal behaviors seeking information which identified the self as an amputee. The children limited information to manageable amounts through behaviors which restricted the amount and type of information received. Limitation behaviors decreased during the later postoperative phases. Alteration behaviors, wishes, fantasies, and dreams, which attempted to change the reality of becoming an amputee, occurred prior to the amputation and then decreased sharply. The children's adaptive responses, behaviors indicating a beginning accommodation to the changes in the "self as amputee" increased with the beginning of mobility training, an event which appeared to represent a degree of restitution.

Affective responses to the "self as amputee" occurred less frequently than adjustive responses. The occurrence of all affective responses except hope or pride remained constant over the four time phases. The most frequent affective response was depression through which the children expressed their sadness and grief about being an amputee. Fearful responses, occurring almost as frequently as depression, were expressed in relation to treatments or other threats involved in being ill, beginning mobility, and the reactions of others to them as amputees. Rejection, expressed through anger or aversion, occurred in response to being an amputee and in response to the appearance of the stump and temporary and permanent artificial limbs. Expressions of hope or pride were few in number and were almost exclusively in relation to their functional capacity or recovery from illness.

The dimensions of the "self as amputee" to which the children referred shifted in relation to the time phases of the hospital experience. The condition of the "self as amputee," including being ill and being an amputee, was the major focus of the children's response throughout the study. However, the proportion of references to the condition of the self *decreased with increasing mobility.* The responses to the physical characteristics were mostly in relation to appearance during the early and later postoperative phases, whereas functional capacity was the focus in the preoperative and middle postoperative phases. Reference to the social aspects of the self occurred least frequently but were observed most often in the middle and later postoperative phases when the children increased contacts in the hospital and prepared for discharge.

In summary, the children were able to begin to adapt to their amputation during the first nine postoperative days. The process of grieving the loss of a body part seemed to occur simultaneously with the striving to establish realistic information about the "self as amputee." The patterns of response to amputation seemed to represent a struggle toward mastery.

● Leadership

The Problem of Leadership in French Canadian Nursing. Detroit, Mich., 1975. Dissertation (Ph. D.) Wayne State University, *by Georgette Desjean.*

This study is a survey of the opinions and perceptions of a selected group of French-Canadian professional nurses concerning the actual state of nursing and of leadership in French-Canadian nursing.

A set of criteria for leadership was developed, and a questionnaire constructed to inquire into four areas considered especially important: conflict and change, roles and functions in nursing, leadership in French-Canadian nursing, and, finally, the university and leadership in nursing.

The final return of the questionnaire came from 62% of the total population: the faculty and students of Laval University and of the University of Montreal.

The findings of the study corroborate the hypothesis that the present situation of French-Canadia nursing offers a picture of poor definition, confusion of roles, apathy resistance to change, social lags, a marked lack of leadership, and low influence.

● Acupuncture

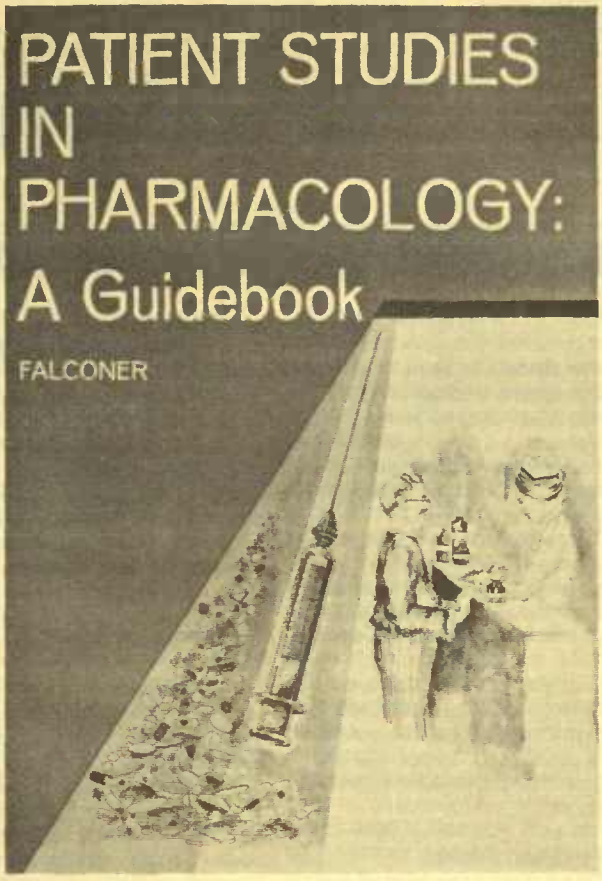
The Effects of Different Techniques of Acupuncture or Knee Pain. Winnipeg, Manitoba 1976. Thesis (M.A.), U. of Manitoba. by *Janice Ramsey.*



The purpose of the present investigation was to determine whi of three techniques of acupuncture (distal, local, or combined distal-loca had analgesic effects on knee pain The three techniques of acupunctu were determined by location of needl insertion relative to the area of treatment. These techniques were compared with similar placebo techniques where needles were inserted one centimeter away from th correct acupuncture point. To determine change in pain, subjects rated their knee pain twice before ar five times after treatment.

The results indicated that there was a significant reduction in pain following treatment and that this analgesia was the same for all group and techniques. Because there wa no difference in degree of analgesi between placebo and acupuncture subjects, it was concluded that a placebo effect was responsible for th pain reduction in this study.

Patient-Oriented Nursing Texts



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Written by the author of the popular **Current Drug Handbook,** this new book underscores the nurse's vital role in teaching patients about the medications they are taking. Case studies cover the pharmacologic care of patients with *hypertension, depression, burns, angina pectoris, leukemia, asthma, menopausal syndrome, glaucoma, parkinsonism, venereal disease, arthritis, hyper- and hypothyroidism, diabetes mellitus, epilepsy, peptic ulcers,* and much more.

A valuable adjunct to any nursing pharmacology textbook, the guide also serves as a useful review for practicing nurses. Answer blanks are provided right on the page; correct answers appear in the accompanying Instructor's Manual. Along with a general bibliography at the beginning of the book, references pertaining directly to the subject being discussed are listed in each chapter.

By **Mary W. Falconer,** RN, MA, formerly, Instructor of Pharmacology, O'Connor Hospital School of Nursing, San Jose, California. 147 pp. Soft cover. June 1976. $5.15. **Order #3545-8.**

Other Valuable References . . .

***Falconer, Patterson & Gustafson:* Current Drug Handbook 1976-1978.** 279 pp. Soft cover. March 1976. $6.70. **Order #3567-9.**

***Luckmann & Sorensen:* Medical Surgical Nursing:** A Psychophysiologic Approach. 1634 pp. 422 ill. Sept. 1974. $21.35. **Order #5805-9.**

***Miller & Keane:* Encyclopedia and Dictionary of Medicine and Nursing.** 1089 pp. 122 ill. March 1972. $13.65. **Order #6355-9.**

***Gillies & Alyn:* Patient Assessment and Management by the Nurse Practitioner.** 236 pp. Illustd. April 1976. $9.80. **Order #4133-4.**

***Kron:* The Management of Patient Care:** Putting Leadership Skills to Work, *New 4th Edition*

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By **Thora Kron,** RN, BS. 247 pp. Illustd. Soft cover. April 1976. $5.15. **Order #5528-9.**

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By **Janet A. Simmons,** RN, MS, M.Ed. 248 pp. Soft cover. April 1976. $6.70. **Order #8286-3.**

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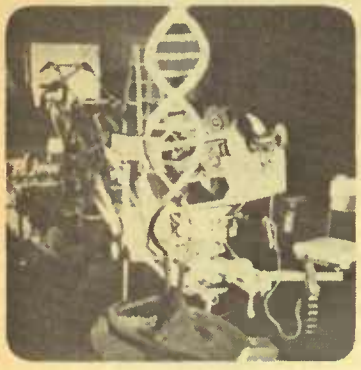
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■ Medicine

Preventing Pressure Sores

This is a slide presentation written for nursing and rehabilitation personnel, health educators, and nursing and vocational school students. The program of 49 color slides and narrative on audiocassette is sold by the Sister Kenny Institute.

Included with each set of slides is a printed sheet containing a list of basic facts about pressure sores, a sample turning schedule, and 4 diagrams showing the bony prominences that are most susceptible to skin breakdown.

Additional information about the slide-audiocassette program on preventing pressure sores, and other educational audiovisuals and publications developed and distributed by Sister Kenny Institute, may be obtained by writing to: Publications — A/V Department, Sister Kenny Institute, 1800 Chicago Ave., Minneapolis, MN 55404, U.S.A.

Chronic Bronchitis and Pulmonary Emphysema

This is a 53 minute film in two parts. Part I (29 minutes) reviews the pathology and physiology of bronchitis and emphysema and demonstrates equipment and diagnostic techniques. Part II (24 minutes) shows the results of a study of the actual treatment and rehabilitation procedures in a well controlled program. This is compared to the results when no planned program is followed. These films may be obtained from your local TB and Respiratory Disease Association.

Management of Chronic Respiratory Insufficiency

This is a 24 minute black and white film that reviews the rehabilitation program for chronic respiratory patients as set up at the D.A. Stewart Center, Winnipeg. This film may be obtained from your local TB and Respiratory Disease Association.

■ Health Promotion

A Matter of Fat

This is a 98-minute color film available in 16 mm and 35 mm that shows how one man shed nearly half his body weight — 140 pounds — by complete starvation, under hospital observation. What brought him to so desperate a course, and how he managed to cope with it, is told with candor and humor by the fat man himself. Lorne Green narrates the rest. Between times, the film leaves Gilles Lorrain and his lonely struggle to examine what other overweight people are doing, singly or in groups, to reduce to more normal proportions. It visits body-contouring parlors, weight-watchers clubs and summer camps. Medical authorities comment on some misconceptions and malpractices of the slimming industry. Available from any regional office of the National Film Board.

■ Health Promotion

Diet Sheets

Diet sheets incorporating the different foods used by ethnic groups are available in 5 languages from the Ontario Hospital Association, 150 Ferrand Drive, Don Mills, Ontario M3C 1H6.

These diet sheets are offered in Portuguese, Greek, Italian, Hungarian, and German. They will be useful for the non-English speaking patient who must adhere to a special diet.

Currently in translation are: gastric III, restricted residue, low fat, and restricted sodium. The sheets cost 5 cents each, $5 per 100 and $4.50 per 100 if ordered in quantities over 1,000.

Food and Fitness

This is a 96-page booklet that discusses the important issues in the relationship between nutrition and physical activity. It is available free to Ontario residents from: Ontario Blue Cross, 150 Ferrand Drive, Don Mills, Ontario, M3C 1H6.

Nutrition

The dietetic services department of the Ontario Hospital Association has published a 1975 edition of *Film and Textbook References,* a comprehensive guide to audiovisual and written materials in general distribution on the subjects of food services, diet, and nutrition.

The guide contains over 400 listings of films, slide shows, and educational literature. It is available, at $2. per copy, from: Dietetic Services, Ontario Hospital Association, 150 Ferrand Drive, Don Mills, Ont., M3C 1H6.

A Global Approach

Poster, maps and charts, monographs, and books on population, food production, United Nations organizational activities, and technological development are available from the Canadian Hunger Foundation, 75 Sparks Street, Ottawa, Ont. K1P 5A5. Write to the Foundation for a list of publications available, with prices.

Health and Welfare Canada Pamphlets

"Antacids," "Cough Remedies," and "The Laxative Habit" are three recent additions to informative heal pamphlets published by the author of the Minister of National Health ar Welfare. They are available from Educational Services, Health Protection Branch, Health and Welfare Canada, Ottawa.

■ Miscellaneous

Brochures

Information Canada publishes eight brochures that describe some the services offered by the federal government. The following brochure are available: Citizenship; Federal Services Employment; Health and Social Security; Youth, Arts, and Recreation; Senior Citizens; Farmir and Fishing; and Housing.

These brochures are available free from any Information Canada center, or write Information Canada Mail Order Service, 171 Slater Stree Ottawa, Ontario, K1A 0S9.

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Books

Nursing Administration; Theory for Practice with a Systems Approach, by Clara Arndt and Louise M. Huckabay, Mosby, 292 pages, 1975.
Reviewed by Karen George, Instructor, Staff Education and Development, Victoria Hospital, London, Ontario.

Based on the premise that administrative theory improves administrative action, the authors attempt to provide practising nursing administrators and students of nursing administration with a theoretical framework for use as a guide to administrative action. While many authors of administrative texts view administrative process as consisting of a set of specific techniques, Arndt and Huckabay portray administrative theory within the systems frame of reference and consider the administrative process as a complex of variable factors.

In the preface, four critical requirements for the solution of most important nursing service problems are outlined — models, concepts, analytical process and data. These become the predominant themes of the remainder of the work.

While the basic functions of the nursing service administrator are not viewed as having altered, the authors propose that the manner in which they are used *has* changed. For the reader who has found other descriptions of the systems frame of reference confusing, Arndt and Huckabay provide an orderly explanation of the systems approach as it relates to nursing administration. Summarily, the model describes the two concepts of administrative process and the open system.

One chapter is devoted to evaluation and measurement. A very complex topic is managed briefly but is sufficiently detailed for the purposes outlined.

Two chapters are outstanding in describing other concepts needed by a nursing administrator and the necessary qualities and specific role expectations required. Chapter 7 discusses change emphasizing systematic analysis of all facets of a proposed change program. It is viewed as a management function to recognize, anticipate and shape changes according to certain criteria. A model for planned change with appropriate diagrams is proposed in some detail with stress on the method of change.

The qualifications and educational preparation of the nursing administrator is discussed in Chapter 11. Her qualifications are divided into three broad categories — (1) intellectual, (2) skills in leadership, operation and communication and (3) personal characteristics, both physical and psychological. The authors perceive the nursing administrator of today situated in a network of mutually dependent relationships, where she must successfully coalign personnel or become obsolete. One of the key words used to describe the nursing administrator is *vitality* — a term connoting fortitude and personal attractiveness in an individual. It is recognized that a leadership position is often a lonely one, eased somewhat through working with others and satisfying staff needs.

Regarding educational qualifications, the authors maintain that schools of nursing should retain the ultimate responsibility for educating nursing administrators through an interdisciplinary approach. A logical rationale for curriculum development is presented accompanied by direction for decisions concerning how to teach in such a program.

Although many of the factors described in Chapter 13, "A Look Into The Future," are specific to the American nursing scene, resolution of our health care problems in Canada will require the same type of shared leadership that Arndt and Huckabay promote.

The illustrations, formulae and diagrams throughout the book are helpful. Reference sources cited at the end of each chapter serve as comprehensive guides to additional reading.

If nurses in leadership positions believe that the future for nursing service administration looks bright, this text is a valuable addition to the body of administrative knowledge concerned with implementing our existing knowledge in a manner that methodically analyzes all facets of the system.

The Common Symptom Guide by John Wasson, B. Timothy Walsh, Richard Tompkins, and Harold Sox, Jr., 353 pages, McGraw-Hill Book Company, New York. 1975.
Reviewed by Nettie Peters, Assistant Professor, School of Nursing, University of Manitoba, Winnipeg, Manitoba.

This book, written by a group of physicians, is a guide to the evaluation of 100 common adult and pediatric symptoms. *The Common Symptom Guide* outlines the relevant historical data and physical examinations required to assess a patient's symptoms. It includes diagnostic considerations for each symptom presented.

The book contains a helpful glossary, and a cross index to enable the user of the guide to find the page best describing the patient's complaint. Thus, for the patient complaining of "weight gain," the health practitioner may find Depression, Obesity, Swelling, listed adjacent to "weight gain" in the index.

A medication section, which includes the names and physical descriptions of some of the common drugs prescribed for a patient's complaint, may also be useful to identify drugs the patient is taking. In addition, a list of common descriptions for symptoms is included in the front and back cover page for easy and quick reference.

Although the book has definite merits as a reference for use by nurses who are involved in primary care activities, certain precautions in its use should be noted. The focus of the 100 symptoms is mainly physical. Little consideration is given to the emotional components of a patient's health status. The *Guide* is by its very nature illness oriented and assists the health practitioner in diagnosing and treating illness. If nurses are interested in using health indices to determine a person's level of wellness in order to further promote health, then this book has limited usefulness.

However, for the purpose of further investigation of common physical symptoms of adults and children, this guide serves as a convenient and compact reference.

Sexual Options for Paraplegics and Quadriplegics, by Thomas O.Mooney, Theodore M. Cole, and Richard A. Chilgren. 111 pages. Little, Brown and Co., Boston. 1975.
Reviewed by Diane Pechiulis, Assistant Professor, Faculty of Nursing, University of Calgary.

At last a comprehensive and well-illustrated handbook on sexuality and sexual techniques for disabled persons has been written . . .

Sexuality and sexual expression of the disabled has too often been ignored as a teaching responsibility by unenlightened health team members because of their own inhibitions or ignorance of basic physiological and psychological facts. Thanks to these three authors, the handicapped now have a sex manual of their own to assist them in deriving satisfaction and enjoyment of a basic physiological and psychological need.

Divided into five chapters and a glossary of terms, this book deals with sexuality generally and sexuality as perceived by the disabled. Preparatory and arousal techniques, oral-genital and manual stimulation, and copulation positions are discussed.

The book is written in easily understood language, and presented frankly with photographs of disabled persons engaging in sex. It would seem to be a useful manual for those who face a sexual adjustment of their own or their partner.

Although the book is presented primarily for the disabled, there is much useful information for the health team member to assist the disabled person with a sensitive area of rehabilitation.

Books

This book should be part of every rehabilitation unit library, for use in Activities of Daily Living education.

The authors, one of whom is disabled, are to be commended for writing a long-needed book on a topic of sensitive concern.

Special Care Units in Hospitals, Health and Welfare Canada, 159 pages, 1976.
Reviewed by Liz Scaife, Teacher, Grace General Hospital, School of Nursing, Winnipeg, Manitoba.

Due to the rapid increase in special care hospital facilities and programs throughout Canada, the need for guidelines and standards for the planning, organization, and operation of these special care facilities has become apparent. This book is the report of the Working Party on Special Care Units in Hospitals, appointed by the Federal-Provincial Committee on Health Insurance to provide these guidelines.

The standards developed in this report are based on information and experience available during the period from 1973 to 1975. It is hoped that use of these guidelines will improve both the quality and the amount of health care, while reducing the costs of care.

Fourteen special care areas are covered, from intensive care and burn units to units for nuclear medicine and the treatment of narcotic addiction. Each special care area is covered in a chapter, which gives the purpose of the unit, the optimum patient load, bed requirements, and criteria for admission to the unit. Administrative policy and procedures, staff requirements in terms of numbers and of qualifications, required equipment, space, and supporting departments, and the recommended distribution of such units, are also outlined. An up-to-date reference list completes each chapter.

The information is presented in a logical and straightforward manner. The detailed table of contents makes it easy to find information on any of the special care units covered, and the reference lists provide the reader with additional sources of information for areas covered by the book.

Although the report is not particularly useful to many nurses, it would be a valuable resource for those involved in setting up or managing one of these special care units.

Ambulatory Pediatrics for Nurses by Marie Scott Brown and Mary Alexander Murphy, 468 pages. Toronto, McGraw-Hill Book Company.
Reviewed by Margaret T. Olsiak, Assistant Professor, The University of Ottawa School of Nursing, Ottawa, Ontario.

The authors stipulate that the book is a synthesis of information dealing in preventive pediatrics which today is an evolving focus of child care. Therefore, the approach is oriented to the child in his non-hospital milieu.

The topic of history-taking concisely delineates the practitioner's specific role as a health team member capable of documenting very meaningful data that pertains to the child's specific health-illness status. The focus is on the individual child's needs, as well as those of his family.

The most outstanding feature of this text is the presentation of valuable reference data in schemata and tables that facilitate a busy practitioner's functioning. Tables such as calculations of homemade formulae, skeletal measures, etc. are outstanding in the areas of both data compilation and reference value. The topic of development and related theories should also have been structured in similar schemata to which the practitioner could refer more easily. The authors needlessly present the fundamental methods of body temperature and pulse rate assessment. Rather, they should have presented the body temperature range and pulse rates for given age groups. The authors do not emphasize that the apical beat is considered the most accurate pulse measurement in infants and is the most commonly used clinically for accuracy.

There are some areas of incompleteness, e.g., the assessor's interpretation of the D.D.S.T. with repeats within a two-week period, and indications of pathological conditions of the resulting extremes of laboratory results. Inclusion of such pathological data would be beneficial to any practitioner to facilitate a complete collection of data and a complete assessment of each client.

Each chapter is documented with bibliographies and nonprofessional sources are used. The use of these sources serves as a very overt reminder to the practitioner that these child care sources are those predominately used by parents, and hence critical awareness as to their value and data accuracy is essential.

The appendices are a source of further resources that would facilitate any practitioner's effectiveness. Such shared data usually takes years for any practicing professional to glean.

Understanding Research in the Social Sciences by Curtis Hardyck and Lewis F. Petrinovich. 224 pages. Philadelphia a, W.B. Saunders Co., 1975.
Reviewed by Pat Hayes, University of Alberta, School of Nursing, Edmonton, Alberta.

Unlike many publications in the area of research and statistics this book is not directly intended for the use of researchers, rather the readers are intended to be consumers of research. The authors' objective is to develop intelligent and critical readers by providing them with the knowledge necessary to comprehend and evaluate differing research approaches and methods of handling data.

The style of presentation takes much of the mystique out of the knowledge required for comprehending research publicatior Headings are clear and content area organized in respect to major concepts in research and statistics. These are defined, discussed, and illustrated in such a way that even the novice at reading research should b able to identify their application in studies within their own discipline. Th six complete research publications included in the text are used both to identify concepts and to evaluate strengths and weaknesses.

The process of evaluation permeates the whole book, focusing on the concepts of research design ir the first six chapters and statistical concepts in the last five chapters.

The last chapter introduces the reader to multivariate statistical methods that include the use of computer programs and printouts. Light printing makes the printouts difficult to read and the complexity o the concepts may be beyond the comprehension of those without some background in statistics. Nevertheless, the authors' rationale for including these complex method (i.e., ..."multivariate analysis will predominate in the future"), demonstrates their philosophy that research is a dynamic process.

This book crosses disciplinary boundaries and is pertinent to anyon functioning in the fields of social an behavioral sciences. It is not intended however, to replace basic texts in research methodology or statistics, although it could be a companion book. For those who feel they are rust in the area and have no readily available texts, it could be a reference As a self-learning text, the concepts are well within the intellectual domai of every nurse. I would certainly recommend this book to those who are novices in the area of research.

Library Update

The following publications, received recently by the Canadian Nurses' Association Library, may be borrowed from the Library by C.N.A. members, schools of nursing, and other institutions. Publications marked **R** however, include reference and archive material and are not available for loan. Theses, also marked **R** are on reserve, and are loaned on an interlibrary basis only.

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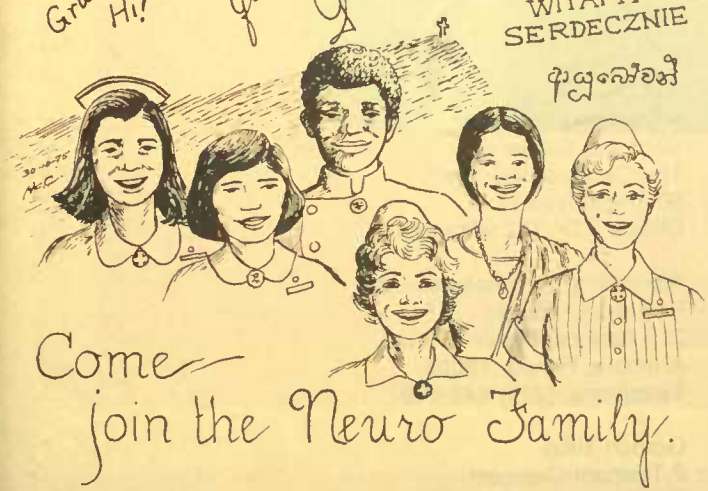
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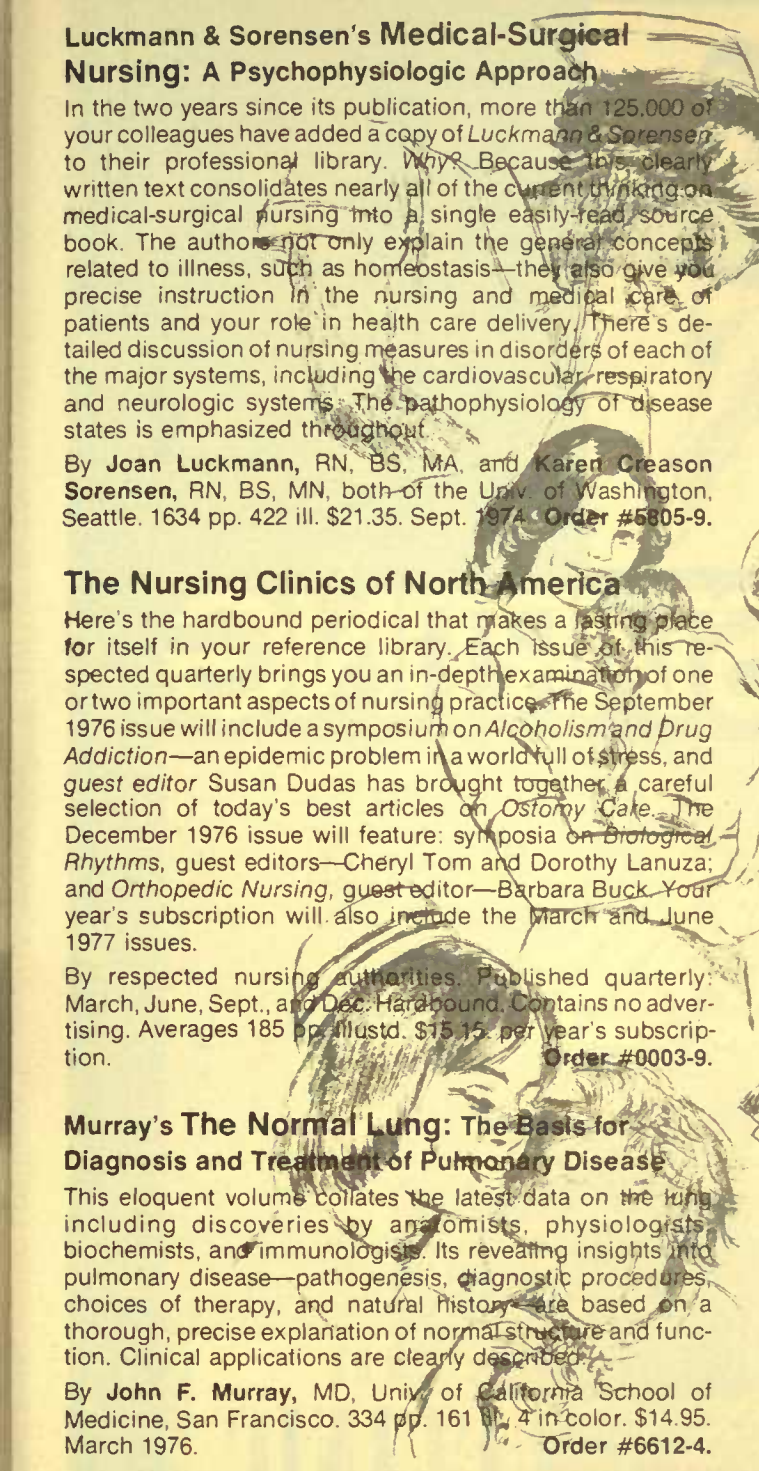
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By **Joan Luckmann,** RN, BS, MA, and **Karen Creason Sorensen,** RN, BS, MN, both of the Univ. of Washington, Seattle. 1634 pp. 422 ill. $21.35. Sept. 1974. **Order #5805-9.**

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By **Dee Ann Gillies,** RN, EdD, the Dept. of Education, Health and Hospitals Governing Commission of Cook County, Chicago, and **Irene B. Alyn,** RN, PhD, Univ. of Illinois College of Nursing, Chicago. 236 pp. Illustd. $9.80. April 1976. **Order #4133-4.**

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By **Gail E. Solomon,** MD, and **Fred Plum,** MD, both of the Cornell Univ. Medical College. 152 pp. Illustd. Softcover. $7.75. March 1976. **Order #8495-5.**

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Changes — The "ever-whirling wheel of change" spins for everyone, even the little girl on the cover. Her photo is supplied by Health and Welfare Canada who also provided the photos for the collage on pages 20 and 21 of this issue.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses' Association.

ISSN 0008-4581

Indexed in International Nursing Index, Cumulative Index to Nursing Literature, Abstracts of Hospital Management Studies, Hospital Literature Index, Hospital Abstracts, Index Medicus. *The Canadian Nurse* is available in microform from Xerox University Microfilms, Ann Arbor, Michigan, 48106.

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Perspective

All too often, for reasons that are not as yet fully understood, it is the heart that proves to be the weakest vital link in what Dr. Hans Selye has termed "the biologic chain that holds our vital parts together."

More than 2,500,000 Canadians of all ages suffer from some form of cardiovascular ailment. More than half of the deaths that occur annually in this country are caused by heart and circulatory diseases.

As nurses, we are all too well aware of what happens when the demands placed upon the cardiovascular system are beyond the capacity of the individual to withstand them. What we tend to forget are the enormous medical advances that have taken place recently in the research, diagnosis, treatment and control of heart disease.

The Canadian Heart Foundation reminds us that today:

- most people who have heart attacks recover.
- high blood pressure (hypertension) can be controlled.
- recurrent attacks of rheumatic fever, which damage the heart, can be prevented.
- most heart defects can be repaired.
- medical science can do a great deal for people with circulatory disorders.

The nurse in the intensive care unit, coronary care unit, emergency or other hospital setting, has an obvious and important role to play in helping cardiovascular patients learn to live and work productively. Less obvious but equally or even more important, is the crucial part that the nursing profession can play in stimulating, developing and implementing primary prevention programs.

More and more evidence is being accumulated to indicate that, for most of its victims, heart disease is a "disease of choice." There are simple steps that anyone — at any age — can take to help protect the health of his heart and nurses are in an ideal position to impress this lifesaving knowledge on the people around them. What we have to say is important — even critical — but it is not new. Thomas Chandler Haliburton said it more than 100 years ago when he wrote:

"The mechanism of the human heart, when you thoroughly understand it, is, like all other works of nature, very beautiful, very wonderful, but very simple. When it does not work well, the fault is not in the machinery, but in the management."

M.A.H.

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Herein



It seems appropriate that the theme we finally settled on for this series on the dynamics of the cardiovascular system should be "Changes." Hopefully, the title will serve as a reminder of the infinite adaptability of the human heart over the span of a human lifetime. The series in its entirety could not have happened without the cooperation of several very concerned and knowledgeable nurses. We thank the authors whose articles appear in this issue and look forward to more of the same high calibre contributions in October and November.

Credit must also go to one particular nurse who was the whirlwind force behind the brainstorming session that was needed to get the series off the ground. She is Penny Jessop, director of public education for the Ontario Heart Foundation for the past three years and author of "Anatomic and Physiologic Dynamics," in this issue.

This issue is also significant because it marks the first time that the work of the Journal's newest staff members — assistant editors Sandra LeFort and Lynda Ford — has appeared under their own byline. By coincidence, both are graduates of the Atkinson School of Nursing, Toronto Western Hospital. Their travels before joining the staff included experience in general surgery, general medicine, intensive care and critical care at hospitals in Toronto, Belleville, Ottawa and Vancouver.

I think that you will like what they can contribute to your Journal and all of us hope that you will find this series one to remember.

Next month . . . "Hypertension: A Major Health Concern", a look at techniques for measuring blood pressure and the story of one successful screening program. In addition, to help you understand your MI patient better, a first-person account of what it's like to suffer a heart attack, as well as numerous other articles in the continuation of this series.

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Input

Recognizing reality

Having read Jo Logan's article, "The Handmaiden is NOT dead," in the May issue of *The Canadian Nurse*, I feel compelled to respond.

I agree that in practice one still finds nurses who act as handmaidens to doctors, but I wonder if perhaps they do so because they feel a comforting sense of safety in a dependency relationship, and perhaps doctors find it flattering. But whose goals are being met? To what end?

I cannot agree that "nurses need physicians," at least, not unless they are ill. Nor can I accept the concept that "nursing educators must retain handmaiden skills in the curriculum," nor that these skills are "urgently required." A curriculum is only valid when it is based on a philosophy of nursing. Those who would teach "handmaiden skills" must believe that the nurse IS a handmaiden of the physician.

It seems to me that Logan's thesis is based on false assumptions. To begin with the key is the patient. Both doctors and nurses serve the patient, and it is the patient who is in the dependency relationship, not the doctor or the nurse, theirs is an *INTERDEPENDENT* relationship.

Many nurses, and some leaders in nursing, believe that of the seven identified functions of the nurse, one is a dependent function, that of "fulfilling the doctor's orders." It seems to me that this is not only an anachronism, but a contradiction in terms. It implies that the doctor is responsible for one aspect of nursing, even though doctors are not nurses.

When prescribing medications and treatments, the doctor is practicing medicine and the patient depends on him to make effective medical judgements. But when the nurse gives the medication or treatment she is nursing, and in failing to carry out these prescriptions she fails the patient, not the doctor. Conversely, if in her professional, independent judgement, she fulfils the medical prescription believing it to be detrimental to the patient, again she fails the patient who is depending on her to serve his best interests.

Furthermore, in those situations where the doctor needs assistance while treating patients, it is the nurse's independent function to render assistance, not because the doctor needs it, but because the patient does. Is this a "handmaiden" role?

It seems to me that nurses must place all these relationships in the proper perspective. Common courtesy between nurses and doctors is required not only because of the professional roles and responsibilities, but because they are people.

If we teach students "handmaiden skills," we perpetuate the past. In order to teach for the future, their future, it would seem more valid to help them understand the meaning of human behavior, their own and others'. Teach them that the interpersonal skills and understandings they learn in schools of nursing, must be used with sensitivity in all relationships, with patients, medical and nursing colleagues, visitors, and others. Let them learn how to ask the right questions, and what the professional roles and responsibilities of the nurse entail. So armed, the novice will be better prepared to cope with the situation as she finds it, and be able to function with a minimum of stress in the changing world of nursing. She may then become an agent of change.

According to the Oxford Dictionary the word "handmaiden" means "a female servant." I find it difficult to believe that Logan intended we should teach our students how to be skillful servants, but I sympathize with the concerns which prompted her to write the article. She is not alone in recognizing the realities faced by novices in the "doctor-nurse game," but we should trust them to demonstrate a new, more effective, colleague role, for "Life goes not backward, nor tarries with yesterday." (Kahlil Gibran. *The Prophet.)*

— Joyce Nevitt, St. John's, Nfld.

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Sex Education for Disabled Persons is a new pamphlet covering parents' and teachers' roles, sex education in the school curriculum, unusual teaching problems and special concerns. Cost: 35 cents from Public Affairs Committee, 381 Park Ave., New York, N.Y. 10016.

Reality — the spice of life

The conflict situation between hospital "realities" and training "ideals" is vividly described by Jocelyn Harper in "Coming Out: A Confrontation With Reality" (July). This would, in particular, apply to those non-hospital based teaching programs where clinical experience comes late (and then, only briefly) in the training period. However, such a conflict is a rather general problem, and is not restricted to the nursing field alone. It is a prevalent trend in modern education to sacrifice comprehensive knowledge and high standards to provide "job-oriented" training (where professional idealism becomes a token matter).

It seems to me, that in order to deviate, i.e. take "short-cuts", from the professed "ideals" of nursing, in situations where staff and time are wanting, the nurse must be aware of what is, in fact, the "ideal" nursing standard. Instant recognition is more likely to follow a training period where these proven guidelines are emphasized, and "peppered lightly" with reality.

So let us "spice" our teaching programs with that inevitable "reality" of the hospital situation, but let us not compromise high ideals in order to provide efficiency at all costs.

— Audrey Moeller-Wiegmann R.N., St. Martha's School of Nursing, Antigonish, N.S.; B.N. Student, McGill University, Montreal, Que.

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	Regular Pantyhose		Sheer Energy®		
Height	Average Size	Queensize	Size A	Size B	Queensize
4'10"			110-130 lbs.		
4'11"			105-135 lbs.		
5'0"	100-130 lbs.	131-180 lbs.	100-140 lbs.		145-180 lbs.
5'1"	95-135 lbs.	136-185 lbs.	95-145 lbs.		150-185 lbs.
5'2"	90-140 lbs.	141-190 lbs.	90-140 lbs.	141-150 lbs.	155-190 lbs.
5'3"	90-145 lbs.	146-195 lbs.	90-135 lbs.	136-155 lbs.	160-195 lbs.
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5'5"	90-145 lbs.	146-200 lbs.	100-125 lbs.	126-165 lbs.	170-195 lbs.
5'6"	90-145 lbs.	146-200 lbs.	105-120 lbs.	121-165 lbs.	170-190 lbs.
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Input

A welcome note

A brief note to say how much I enjoy the "new" *Canadian Nurse*. May I congratulate the staff on their fine editorial work.
— *Ann Parsons, Burnaby, B.C.*

"Sunny-side-up"

In reply to Jocelyn Harper's article: "Coming Out: A Confrontation with Reality," I would say to her:
1. Don't give up your professional ideals.
2. Talk to the head nurse on your unit. She will welcome your contribution to and initiation of patient care plans.
3. Have ward conferences (even if only for 20 minutes) with as many RNs and PNs as is feasible to formulate individual patient care plans. You will be surprised how much they will contribute to care.
4. Be patient with hospital administration. Things can be changed by going through the proper channels. Consult with your head nurse about this. She is receptive to change and innovation.
5. By maintaining your own high standards, you will set an excellent example for the rest of the staff.
— *Evelyn Mosher, R.N., Vancouver, B.C.*

Occupational hazard?

I was very pleased to see an article on Occupational Health Nursing in your July issue, particularly as it covered an aspect often neglected or misunderstood, "the Nurse's role in the work environment." Anything which helps to dispel the image of Occupational Health nurses as "Knitters and Stickers" is to be welcomed and Hayman's article covers a very broad area succinctly and well ...

Your readers may like to know that the Occupational Health Nursing Course offered by Grant McEwan Community College is 300 hours in length and is being offered as evening classes at present. The first nurses graduated and were awarded Occupational Health Nursing Certificates this year and are to be congratulated on the hours of hard work needed to achieve this in addition to their full time jobs.

Anyone requiring more information should write to Ms. Rhea Arcand, Grant McEwan Community College, 7319 — 29 Avenue, Mill Woods, Edmonton, Alberta.
— *Elizabeth M. Butler, RN, OHNC, Dip. Nursing (London), Occupational Health Nurse Consultant, Medical Services Branch, Alberta Dept. of Labour.*

Brain teaser

I just thought I would take this opportunity to write and tell you how much I enjoyed the Clinical Wordsearch No. 1 in the last *Canadian Nurse*. I found it a very interesting way to get me thinking! Hope the No. 1 means there will be many more to follow.

Congratulations on a much improved magazine. I enjoy the articles and look forward to each issue.
— Heather Ducharme, R.N., Brandon, Manitoba.

An independent view

I'm just one of those nursing students that all nurses have been at one time in their lives, and, as yet, have never assisted in an abortion procedure. I have never had to account for myself in this type of situation, in the capacity of a nurse. However, I'm thankful that somebody out there spoke out about the article entitled, 'What Are the Bonds Between the Fetus and the Uterus.'

I couldn't agree more with Bettie Scheffer's 'Input' in last May's issue. I, too, was astonished at the lack of objectivity and unbiased facts in the article. As I read it, I found it difficult to believe that I was reading a magazine that supposedly promotes professionalism and open, intelligent thinking for Canadian nurses.

The author of the article, V. Adamkiewicz, appeared to judge any nurse who assisted in abortions as callous and uncaring, and attempted to inflict guilt on those nurses who agree with abortion.

We need articles with unbiased facts that can be used to formulate our own, independent opinions, not harsh (and sometimes unwarranted) criticism!
— *Carolyn Czartorski, Ottawa, Ontario.*

Our readers say ....

I would like to answer Charles W. Lindsay whose letter appeared in Input, May, 1976. I feel that this or any other would be an inopportune time to suggest a combined English/French edition of *The Canadian Nurse*. Don't deny the English-speaking Canadian his right to a publication in English. Please don't change.
— *Patricia Black, R.N., Flin Flon, Manitoba.*

... don't want to miss any issues. Really like your new format. The Journal has improved immensely!
— *Robin M. Scobie, Kasco, B.C.*

....I'd like to tell you I think I've got more information and enjoyment out of the last six issues of *The Canadian Nurse* than all the five previou previous years I've received it altogether. Congratulations on a terrific job!
— *Faye Denys, Saskatoon, Sask.*

Last year's model?

With regard to the article "Storyboarding: A Teaching Tool" June, 1976, I agree that communication tends to be more successful when both sight and sound are used to reinforce the basic message. However, one of the basic rules of using pictures or films in teaching is that they should be up-to-date. The pictures in this article distracted me from the article itself since the use of a common can of cotton balls and pick up forceps in an open-ended container certainly isn't up-to-date when considering Infection Control in hospitals.
— *D. Pequegnat, Infection Control Officer, Ottawa Civic Hospital.*

Huntington Society formed

The purpose of this letter is to announce the formation of the Huntington Society. For many years Huntington's Chorea, a hereditary illness, has been hidden by affected families. It is our wish to bring it out into the open and to reach not only affected individuals and families, but also those who offer care and professional service to those affected by the disease.

The Huntington Society of Canada was recently established t aid in the battle against Huntingtor Chorea, a hereditary degenerative disorder of the nervous system. Th illness is characterized by the association of abnormal involuntary "jerky" movements and a progressi mental illness. It is a disease determined by a so-called dominar gene, and therefore will be passed c from generation to generation, with every new child having a 50 perce probability of eventually developing the disease if either parent is affecte Unfortunately the signs of the disord usually appear after the age of 30, when most persons have already married and had children. The gen although relatively rare, is still prese in 1/10,000 persons.

The goals of the Society are Research, Education, and Family Assistance. Available on request is family booklet in English or French and a Handbook for Health Professionals. Already Chapters of the Society have been established several provinces. This non-profit, voluntary organization is registered a a Charity by the Federal Governmer

For further information please contact: Huntington Society of Canada, Box 333, Cambridge (Gal Ontario, N1R 5T8.
— *Ralph Walker, president.*

Did you know?

Do you or your patients suffer from migraines? The Migraine Foundation has a pamphlet, availab to the public, which gives simple directions and suggestions indicatir how migraine sufferers can help themselves before and during an attack.

The Migraine Foundation is als attempting to conduct a survey of known migrainers in Canada and hav questionnaires which they will glad send to industries, organizations or individuals.

To receive the pamphlet or questionnaire, contact: The Migraine Foundation, 390 Brunswick Ave., Toronto, Ontario, M5R 2Z4.

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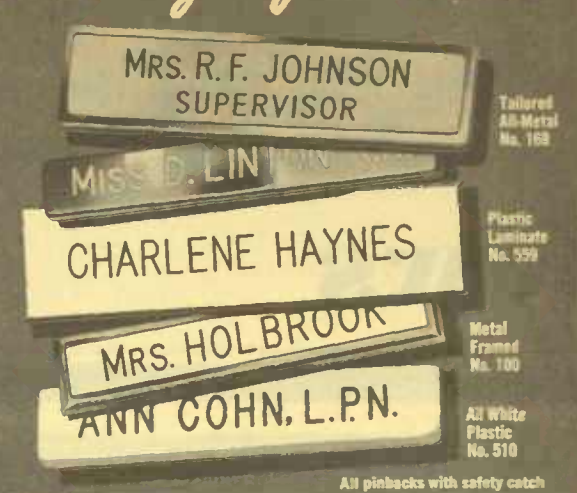
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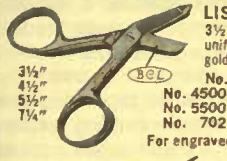
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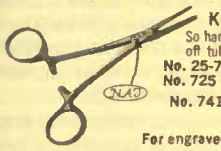
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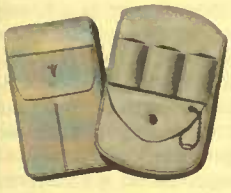
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Handiest for busy nurses. Includes white Deluxe Pocket Saver, with 5½" Lister Scissors (both shown above), Tri-Color ballpoint pen, plus handsome little pen light . . . all silver finished. Change compartment, key chain.

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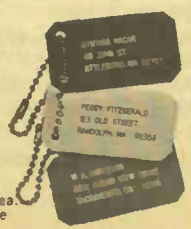
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News



Six Canadian nurses were among participants in the third International Nurses' Seminar sponsored by King's Fund College and held in London, England in late July.

The conference theme was "leadership" and discussion topics included the nature of leadership, definition of the role and responsibility of nurses for leadership in a health care delivery system, emergence of leaders and evaluation of leadership.

Pictured with King's Fund College Director Frank Reeves, during the seminar, are: front row, (left) Shirley Stinson, professor, school of nursing and Division of Health Services Administration, Edmonton, Alta.; and Huguette Labelle, principal nursing officer, Health and Welfare Canada; back row (left to right) Helen Mussallem, CNA executive director; Ada McEwen, national director, Victorian Order of Nurses; Dorothy Kergin, Associate Dean of Health Sciences (Nursing) McMaster Health Sciences Centre, Hamilton; Lorine Besel, director of nursing, Royal Victoria Hospital, Montreal.

Special loan fund for 1976 grads in Ontario

A limited number of loans will be granted by the RNAO to 1976 graduates of basic nursing programs in Ontario. The maximum amount of the loan is $250. and is available to those nurses who wish to pursue post-diploma or post-degree nursing education programs. For further information and/or application form, write to: Executive Director, Registered Nurses' Association of Ontario, 33 Price St., Toronto, Ontario, M4W 1Z2.

Hospital allows Parents in OR

McMaster University Medical Centre in Hamilton, Ontario is apparently the first hospital in North America to allow parents into the operating room during induction of anesthesia in their children. They are also in the recovery room when the child regains consciousness. After a sucessful pilot study, the pediatric outpatient clinic program (POPS) is now being extended to different types of pediatric surgery.

NB. nurses discuss resolutions on soc and ec benefits and conditions

Negotiations and employment proved the key issues discussed by members of the New Brunswick Association of Registered Nurses at their annual meeting in June. The resolutions voted on are as follows:

- A resolution calling for NBARN's full support of the provincial Collective Bargaining Councils in their efforts to improve salaries and working conditions for New Brunswick nurses received unanimous approval.

The resolution pointed out that many nurses are receiving a lower wage than the hospital workers they supervise. An unsatisfactory settlement from current negotiations will widen the disparity, it added, which could lower standards by loss of nurses from the profession and the province.

- Nurses at the meeting supported the broadening of the "Employment Practices Guidelines" to assist the 2200 New Brunswick nurses not in a bargaining unit to obtain adequate social and economic benefits.
- A resolution was accepted discouraging immigration of out-of-country nurses when there are sufficient nurses to meet employment needs.

The resolution also pointed out that some N.B. nurses are presently having difficulty finding employment in their own province. Association registrar Eva O'Connor presented statistics on nurses coming into New Brunswick which indicated a significant rise in the number of non-New Brunswick nurses registered in the province in the first six months of 1976 over the previous year.

The Registrar advised members that a letter explaining the employment situation in New Brunswick and the other provinces has been sent to the Canadian Embassy in the Philippines, where many requests for registration originate. The situation has also been discussed with the Department of Immigration, and a form letter has been sent to out-of-country applicants providing employment information and advising them to be assured of a position before completing plans to immigrate.

- Nurses defeated a resolution calling for the Association to do all i its power to prevent an over-abundance of nurses.

The concern expressed here wa that cutbacks in nursing school enrolments could cause a future shortage of nurses in New Brunswic

- A resolution calling for NBARN t limit its budget increase for next yea to 10% was defeated.
- A resolution proposing that the fee increase be split over a two-yea period was over-ruled by the previou vote in favor of the $65 fee hike.
- A resolution was accepted callin for an increase in the non-practicin membership fee from five to eight dollars next year and from eight to te dollars the year after.
- Members resolved that the Association reiterate its anti-smokin stand and actively support this position.

This resolution referred to a 197 Canadian Public Health Association study which illustrates that over 44 of New-Brunswick nurses who belon to that organization are current smokers. This compares with the 26 national average and is the highest o all provinces. The resolution also pointed out that public health nurse serve in an exemplary role.

- Resolutions referring to registered nursing assistants were accepted which oppose the employment of RNAs in the public health field and call for an increase the ratio of RN's to RNAs and for th RNA to remain under the direction o the RN in the practice setting.

Did you know?

The five most prevalent pathogens occurring in American hospital patients during 1975 were E. coli (20.1%), Staphylococcus Aureus (12.0%), Proteus (8.0%), Klebsiella (7.7%) and Pseudomonas (7.5%) according to a study done by Bac-Data Medical Information Systems Inc., Clifton, New Jersey.

Among all isolates, gram-negative organisms represented 57%; gram-positive, 43%.

Respiratory interest group formed

R.A. Dutcher, President of the New Brunswick Tuberculosis and Respiratory Disease Association, has announced the formation of a Respiratory Interest Group in Fredericton. This interdisciplinary educational resource group is an affiliate of the N.B. TB and Respiratory Disease Association (the Christmas Seal People) and the second of its kind to be formed in Canada. The first such group is in Winnipeg.

The Respiratory Interest Group includes representatives from all health care disciplines: nurses, physicians, respiratory technologists, and other interested professionals and non-professionals from a variety of community health care institutions and agencies.

Chairperson of the Group is Margaret Irwin, physiotherapist at Victoria Public Hospital, Vice-chairperson is Louise Smith, Nurse Clinician in Oromocto, formerly involved in Winnipeg's Respiratory Interest Group.

The objective of the Respiratory Interest Group is to improve the prevention and management of respiratory diseases by encouraging an inter-disciplinary approach, promoting interprofessional and public communications, providing a means for professional development through continuing education, and serving as a stimulus for the formation of non-professional interest groups.

Interested nurses may contact Alma Leclerc, RN, Program Director, New Brunswick Tuberculosis and Respiratory Disease Association, P.O. Box 1345, Fredericton.

Why not?

The results of a nation-wide government survey on attitudes towards the status of women indicated a 20 per cent shift in the attitudes of both sexes towards women's equality between December 1974 and December 1975. The results of the survey were released in July by the Minister Responsible for the Status of Women, the Honorable Marc Lalonde.

The survey was designed to show current attitudes on women's roles and potential abilities and to measure any changes in attitude that occurred during 1975, International Women's Year. Attitudes on such topics as equal employment opportunity, child care, marital property division, custody of children, and women working in the home were investigated.

In releasing the survey results, the Minister noted that this was the first comparative evaluation survey on attitudes conducted by the government and this fact indicated the high priority the government placed on status of women concerns.

The survey indicated that 86 per cent of the population was aware that 1975 was International Women's Year, and that 74 per cent of the population recalled the "Why not" advertising for the year.

Nurses will be heard

As a guest speaker of the New Brunswick Association of Registered Nurses' Annual Meeting held in Fredericton in June, Mary Kay Harrison spoke out in favor of a more positive attitude among nurses and delivered a hard-hitting critique of the "doctor-nurse game".

Harrison, of the University of Toronto's Faculty of Nursing, delivered the keynote address entitled "Today's Nurse — A Dynamic Professional", as well as conducting a workshop "Nurses Will Be Heard!".

In her workshop, Harrison stressed the complementary rather than subservient role of nurses in their relationship with doctors. She said that although nurses have a different role than doctors in the care of patients, it is in no way to be considered a less important role.

Harrison suggested consciousness-raising groups and human relations workshops as the means to making nurses more comfortable with themselves, and thus more assertive and responsible in their professional role. She concluded the workshop with a warning to nurses: "If you act like a doormat, you'll get treated like a doormat."



Photo by Wamboldt-Waterfield.

The Nursing Sisters Association of Canada held its 25th biennial meeting in Halifax during the CNA annual meeting. Approximately 100 nurses who served in two World Wars attended. Two former Matrons of Canadian units, Blanche Herman (center R), and Nancy Kennedy Reid (R), are pictured with the association's honorary president, Evelyn Pepper (L), and national president, Agnes Butler (center L).

AARN supports university education for all Alberta nurses by 1990

The Alberta Association of Registered Nurses has endorsed the suggestion of the Alberta Task Force on Nursing Education that all professional nurses graduating after 1990 in the province should have a university degree. Support for the proposal was contained in a Response to the Report of the Task Force submitted by the AARN to the province's Minister of Advanced Education and Manpower, Dr. Bert Hohol, in mid-July.

In endorsing the recommendation the AARN agreed that the professional nurse of the future will need a broader educational base to meet the changing health care needs of Albertans. The Association supports the view of the Federal Ministry of Health that within the health delivery system more emphasis must be placed on promotion and maintenance of health as well as the curative and rehabilitative aspects of illness.

The two routes of attaining a university degree in nursing outlined in the Task Force Report (a university based program and a joint program between college or hospital and a university setting) were also agreed to by the Association.

In the response the AARN recognizes that a university degree for nurses by 1990 will only become a reality if priority commitment is received from both government and the concerned professionals. Upgrading of the educational preparation of nursing instructors must occur. The Association urges the establishment in Alberta of more nursing programs at the Master's level. Sufficient financial assistance must also be available to support nurses who wish to advance their education.

The Association rejected the Task Force's recommendation regarding monitoring of nursing education and advocated that an organization outside government be given the responsibility and authority for establishing and monitoring standards of nursing education. The AARN endorses the statement in the 1972 report to the Alberta Government of the Commission on Educational Planning that the Professional Association is the most appropriate body to perform the monitoring task.

News



A Canadian Association of University Schools of Nursing (CAUSN) Committee on Accreditation concerned with the development of a tool for the evaluation of university faculties/schools of nursing in Canada, has been awarded financial support by the Canadian Nurses Foundation. The support, in the form of a $5000 grant from the CNF, will enable CAUSN to continue work on the project.

CNF secretary-treasurer, Helen Mussallem, (center) made the official presentation of the cheque to CAUSN representatives, Sue Finch (left) chairman of the Committee on Accreditation and Ruth McClure, CAUSN president, during the recent annual conference of CAUSN held in conjunction with the Learned Societies in Quebec City.

Neuro nurses meet

The Seventh Annual Meeting of the Canadian Association of Neurological and Neurosurgical Nurses was held in Winnipeg this past June. Despite the air strike which was in full swing, 84 nurses from Canada and the United States attended the conference.

The conference included a day of workshops, a day of scientific presentations, and a half day of special presentations, all of which were of excellent quality. Dr. B. Jeannett, Professor of Neurosurgery from Glasgow, Scotland and special guest of the 1976 Congress of Neurological Sciences spoke to the delegates on "Head Injuries".

CNA issues statement on fiscal constraints

CNA Directors, meeting in Halifax following the Association's annual meeting and convention in June, approved an official CNA Position Statement on a subject of national concern — fiscal constraints in health care services. The text of the statement reads as follows: "The Association has repeatedly requested that governments put forth plans to re-focus the Canadian system of health care in order to expand services in the directions of health education, health promotion and primary care. Groups of nurses across the country urge the provision of realistic alternatives to our present over-reliance on costly, acute care facilities.

The Association supports the Federal Government in its steps to broaden the cost sharing arrangements with provincial governments in order to encompass not only acute care facilities and services but all health facilities. This organization will work in concert with government and voluntary agencies to achieve that end.

The Association also strongly urges greater emphasis on home care programs, occupational, industrial and school health programs. At the same time, the Association is firm in its commitment to promote an approach to health care that achieves cost effectiveness which is compatible with an optimal level of health for all Canadians."

N.B. negotiations reach stalemate

After three months of negotiations, contract talks between the New Brunswick Nurses Provincial Collective Bargaining Council (PCBC) and the Province's Treasury Board broke down in late June.

In line with the steps laid down by the Public Service Labour Relations Act in the event of a breakdown in negotiations, PCBC has applied for and been granted a conciliation board. This three-member board will rule on the contract dispute after hearing evidence from both sides.

One member of the conciliation board is nominated by the nurses and another by Treasury Board. These two members then nominate the third board member who serves as chairman.

The contract for New Brunswick's 2300 public hospital nurses expired March 31, 1976. According to Glenna Rowsell, spokesman for the Bargaining Council, 17 of the 52 items in the contract were unsettled, including the wage issue. The nurses' last wage proposal called for an increase from the basic $721 per month to $945 (31%) in one year. Treasury Board's last offer called for two $74 per month pay hikes bringing the basic salary level to $869 per month October 1, Rowsell said.

One of PCBC's major concerns is the present discrepancy between the salary of the RN and that of the RNA whom she supervises. The historical wage relationship between the two groups was lost when the RNAs signed their last contract. PCBC is seeking to have the historical relationship restored.

RNAs presently earn a basic yearly salary of $8715 which will go up to $9599 in October. The basic RN salary amounts to $8652, the rate currently in effect under the expired contract. In addition, the RNA contract comes up for negotiation at the end of this year.

Nurses have traditionally earned 25-30% more than RNAs to reflect their lengthier training, responsibility for total patient care, as well as responsibility for the supervision of RNAs and others involved in patient care.

Did you know?

The Department of National Health and Welfare has awarded 26 grants totalling $25,000 as part of the final phase of the department's International Women's Year funding program.

The Canadian Indian Nurses Committee based in Winnipeg, Manitoba received a $400. grant to reprint 1,000 copies of their IWY Project Report consisting of material presented at and arising from "The First Assembly of Registered Nurses of Indian Ancestry."

Calendar

September

10 Year Reunion at the School of Nursing of Memorial University of Newfoundland for all graduates of the school. To be held from Sept. 2 — 26, 1976. For information, contac *The School of Nursing, Memorial University of Newfoundland, St. John's, Newfoundland.*

October

Ischemic Heart Disease — An Inaugural Symposium to be held the Talisman Motor Inn, Ottawa on Oct. 1 and 2, 1976. The Symposium i sponsored by the University of Ottaw Cardiac Unit, Ottawa Civic Hospital and the Canadian Heart Foundatio and is open to all interested personne in the cardiac field. Registration fee $50. For further information contact *Mrs. E. Masson, University of Ottaw Cardiac Unit, Ottawa Civic Hospita 1053 Carling Ave., Ottawa, Ontario K1Y 4E9.*

Workshop in Psychodrame to be held at the Faculty of Nursing, University of Toronto on Oct. 1 - 2, 1976 and Dec. 3 - 4, 1976. Fee:$50.00. For further information contact: *Mrs. Dorothy Brooks, Chairman, Continuing Education Programme, Faculty of Nursing, University of Toronto, Ont., M5S 1A*

Annual Rehabilitation Nursing Course for Registered Nurses and Registered Psychiatric Nurses at Wascana Hospital, a division of the South Saskatchewan Hospital Centr Regina, Saskatchewan to be held from Oct. 18 - Nov. 5, 1976. For information, contact: *Mrs. Audrey Balon, Co-ordinator of 1976 Rehabilitation Nursing Course, Wascana Hospital, 23rd Avenue an Avenue "G", Regina, Saskatchewa S4S 0A3.*

Annual Conference of Ontario Occupational Health Nurses Association to be held at the Park Hotel, Niagara Falls, Ontario, Oct. 26 - 29, 1976. Information from: *Ann L. O'Brien, Publicity Chairman, OCHNA, 320 Queenston Rd., St. Catharines, Ontario.*

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Names and Faces

In recognition of her distinguished service to the nursing profession, **Margaret M. Street** (B.A., U. of Manitoba; R.N., Royal Victoria Hospital, Montreal; M.S., Boston University, Boston, Mass.) was presented with an "Honorary Membership" in the Alberta Association of Registered Nurses.



Street is past president of the AARN and a former Associate Director of Nursing at the Calgary General Hospital. In 1972, she retired as an Associate Professor Emerita from the University of British Columbia School of Nursing. She has been an extremely active member of both the AARN and RNABC as well as having served on committees with the CNA. Her best-known publication is "Watch-fires on the mountains: the life and writings of Ethel Johns."

Margaret (Peggy) Mitchell was honored with the 1976 "Nurse of the Year" award, presented by the Alberta Association of Registered Nurses' Annual Convention. Mitchell has been the Special Project's Coordinator at the Alberta Children's Hospital, Calgary, where her main focus has been on the importance of people as individuals and excellence in nursing care. She has been involved in many community projects including the organizing and supervision of a teen drop-in center.

The "Nurse of the Year Award," initiated in 1965, is presented annually in memory of the late Abe Miller, Legal Advisor to the AARN. It is designed to honor those who participate in community affairs.

Karon Croll of Moncton has been named incoming Executive Secretary of New Brunswick Association of Registered Nurses. Croll's appointment was announced by the President, Simone Cormier, during the Association's annual meeting in June.

A native of Yarmouth, Nova Scotia, the new Executive Secretary has spent most of her nursing years in Moncton both as a staff nurse and a nurse teacher. She graduated from the Moncton Hospital School of Nursing (1965), and holds degrees in nursing and education from Université de Moncton. Croll is presently completing requirements for a master's degree in adult education at the University of Maine in Orono.

A graduate of the University of Montreal Faculty of Nursing, **Francine Gratton-Jacob** is the recipient of the 1975 Warner-Lambert Canada Limited Nursing Fellowship award made annually by the company's Warner-Chilcott Laboratories Division.



Warner-Lambert makes the $750 cash award available each year to a promising nursing graduate to assist the nurse in furthering her knowledge and experience in the field of nursing.

Gratton-Jacob is seen receiving the award from Yves Bordeleau, left, Field Sales Manager for Quebec and the Maritimes. Jeanne Reynolds, Dean of the Faculty of Nursing, U. of M. is on the right.

Dr. Rae McIntyre Chittick was recently awarded an honorary Doctor of Science degree at the Health Sciences Convention at McGill University. Chittick received her formal education at Johns Hopkins School of Nursing, Columbia University and Stanford University in nursing and education, and received a Master of Public Health from Harvard University in 1951.

She has held the position of Director of the School for Graduate Nurses at McGill and was instrumental in the development of the Bachelor of Science in Nursing and of Master of Science (Applied) programs at McGill. She is past-president of the CNA, AARN, and past vice-president of the ONQ and as such her influence has spanned local, national and international levels. She also served with WHO establishing university nursing programs in Ghana, Jamaica and New Zealand.

At the convocation, Joan Gilchrist, newly elected president of CNA, described Rae Chittick as a great Canadian, nurse and teacher who truly epitomizes a dedication to equality, cultural integrity and human value.

Carol Whiting (R.N., The Wellesley Hospital school of nursing, Toronto; B.Sc.N., M.Sc.N., University of Western Ontario, London) has been appointed director of nursing services, The Wellesley Hospital, Toronto. She had been associated with Wellesley throughout her nursing career until she joined the staff of the Ryerson Polytechnical Institute in 1973, when it assumed responsibility for the Wellesley school of nursing.

Whiting has been a Canadian Nurses Foundation scholar.

A. Joyce Bailey (R.N., The Wellesley Hospital school of nursing; B.Sc.N., University of Toronto; M.Sc.N., Western Reserve College, Cleveland, Ohio) has been named assistant administrator, patient services, The Wellesley Hospital, Toronto. Formerly director of nursing service, she has held several positions during her association with Wellesley, with time out for educational leave. She has been a Canadian Nurses Foundation scholar.

Jean Livingstone nurse in charge a the Fort Providence nursing station i the recipient of the Judy Hill Memoria Scholarship. She has been awarded a $3,500 grant to study midwifery in Edinburgh, Scotland.

After graduating from St. Franci Xavier University, Livingstone practised general duty nursing in Antigonish, N.S., and Victoria, B.C., and was Assistant Director of Nursing at North Battleford Indian Hospital and also served at the Charles Camsell Hospital in Edmonton. For the past two and a half years, she has been employed by the Northwest Territories Region of Medical Services and has worked in many nursing stations in the north.

The Judy Hill Memorial Fund was established to commemorate the memory of Judy Hill who died while accompanying patients on a mercy flight in 1972. These scholarships are awarded annually to enable nurses to improve their education for service in the Canadian Arctic.



The Canadian Medical Association has announced the appointment of **Dr Bob Wilson,** Vancouver, B.C. as Secretary General. Dr. Wilson, currently an assistant professor at U.B.C. and coordinator of the Family Practice Unit assumed his responsibilities at CMA House in Ottawa on Sept. 1, 1976.

Dr. Wilson has extensive experience in organized medicine in Canada having served as Medical Economics and Executive Secretary of the B.C. Medical Association for 15 years.

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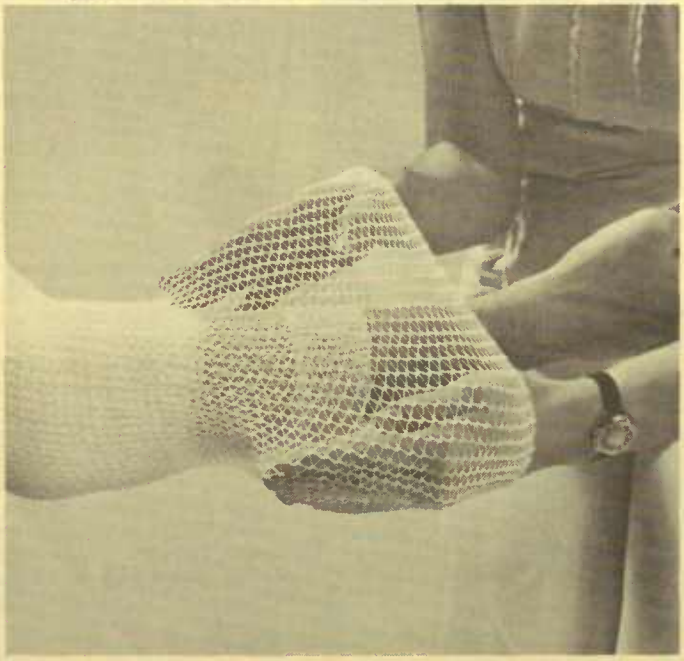
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Cardiovascular disease in Canada is estimated to cost over $1.2 billion each year.[1] Advances made in the treatment of cardiovascular diseases have decreased the mortality rate associated with them, but the incidence of such diseases may nonetheless be termed epidemic. Leading epidemiologists suggest that control of this epidemic can only be attained through primary prevention...

FOCUS on PREVENTION

Betty Oka.



There is nothing new about coronary heart disease — evidence points to its existence in ancient Greek and Roman times.[2] But the twentieth century has seen the disease rise to epidemic proportions, particularly in western and industrialized countries. Fifty per cent of the deaths recorded in Canada in 1971 were related to cardiovascular disease — "heart attack", the major cause, leading other cardiovascular diseases. Although death rates related to cardiovascular disease other than "heart attack" have decreased significantly since 1950, there has been only a ten per cent decline in deaths resulting from "heart attack".[3]

The decrease in mortality rates associated with cardiovascular diseases is primarily due to the tremendous advances in diagnosis and treatment of the acute attack. There can be no dispute over the impact of the coronary care unit and increased nursing knowledge and skill on the recovery of those suffering an acute myocardial infarction. But many persons continue to develop this disease and a great number die before they reach a hospital.

Along with the mounting incidence of coronary heart disease and its devastating physiological, psychological and sociological effects, soaring economic costs for treatment are of paramount concern. Cardiovascular disease in Canada is estimated to cost over $1.2 billion each year.

Leading epidemiologists suggest that control of this epidemic can only be achieved through primary prevention. Concerted effort must be exerted to reduce the initial development of atherosclerosis. Contrary to popular belief, atherosclerosis is not a natural result of growing older, but is, in fact, a disease, often having its origin at a very early age, and showing itself clinically in the third and fourth decades of life — the prime productive years. Health professionals must now emphasize the prevention of this disease to curtail both the loss of productive years and the soaring costs involved in its treatment.

Epidemiological research has identified many causative factors influencing the development of coronary heart disease. Although such factors as heredity, sex and age are not subject to change, most of these predisposing factors can be linked to the life style associated with advanced industrial and western nations. Stamler states: "Without a doubt, the 'easy' life is killing us from the inside out".[4] The main risk factors inherent in our life style seem to be associated with a rich diet, obesity, high blood pressure, smoking, stress, and lack of physical exercise. The relative importance of causative factors related to the development of cardiovascular disease is a subject of debate among researchers. There is agreement however, to the fact that such factors do increase the risk of disease, and that they can be prevented.



Risk Factors

A multiplicity of environmental factors, along with inherited tendencies contribute to coronary heart disease. The following risk factors are amenable to change. Through preventive programs and teaching in these areas, we can hope to decrease the incidence of cardiovascular disease, our twentieth century epidemic.

Eating Style

- Dietary habits in Canada are similar to those in other affluent countries — rich, and high in animal fat.
- The intake of excessive calories along with high cholesterol and saturated fat intake seems to play a major role in causing hyperlipidemia. In Japan, where people eat far less animal fat, they tend to have much lower blood cholesterol levels, and there is a significantly lower incidence of coronary heart disease.

Cigarette Smoking

- Probably a major factor in the development of coronary heart disease.
- Associated with the interference of oxygen intake, effects on cardiac function, and a higher incidence of hyperlipidemia.
- Among the younger age groups, the risk of dying from coronary heart disease is two to three times greater among cigarette smokers.[5]

Hypertension

- Now recognized as a main contributor in the development of premature atherosclerosis.
- The ideal blood pressure has not been identified, but findings indicate that at the arbitrary hypertensive level of 150/90, there is a marked increase in the risk of coronary heart disease among both sexes aged 40 to 59.[6]
- Of concern is the large proportion of the population with hypertension that goes undetected, untreated, or is inadequately treated.

Obesity

- Obesity related to diabetes or hypertension is unquestionably a significant risk factor.
- Uncomplicated slight or moderate obesity in itself may not be a crucial factor, but the type of food eaten does increase susceptiblity to coronary heart disease.

Physical Inactivity

- Research indicates the benefits of regular physical exercise on cardiopulmonary fitness, and on general well-being.
- Exercise not only affects cardiac fitness, but also influences the control of other risk factors. Blood pressure may be lowered through exercise, triglyceride levels decrease, there is improved handling of carbohydrates by the body, and le catecholamine is excreted in response to stres
- It has been shown that there is a significant decrease in the resting heart rate associated w the maintenance of regular physical exercise.
- It is also believed that the improved cardiac contractility results in an increased stroke volu and decreased cardiac work load.
- It appears that there is a relationship betwee lowered heart rate and mortality. Stamler has shown a significant increase in the death rat men 40 to 59 years of age with resting heart ra greater that 80 beats per minute, as compare those with heart rates below 60 beats per minut
- The exact mechanism by which exercise enhances health of the heart muscle has not be determined, but positive findings indicate that exercise has a place in the prevention of cardiovascular disease.

Psycho-Social Stress

- The direct effect of personality traits and chro stress on the development of coronary heart disease has been the cause of much controver
- Today's life styles — the tensions, pace and turmoil of the urbanized society — may potenti other risk factors.
- Physiological responses to stress do have a negative effect on the cardiovascular system
- The aggressive, achieving, hurrying behavior described by Friedman and Rosemann as "Ty A" behavior, may be a significant result of contemporary society.

A Challenge for Nurses

The many aspects of heart disease offer a broa range of nursing opportunities, but the key to reduction in morbidity is through prevention. Th 'hows, wheres, and whens' of effective preventi programs and methods of implementation of th programs present a significant challenge to the nursing profession. To discover the answers to th questions, input is needed from a variety of hea disciplines as well as from those involved in the behavioral and educational fields. Many new ro for nurses will evolve to meet these challenges. involvement of nurses is needed from many areas expertise. Where shall such preventive program begin... among the high risk group?... among th young? Where do we begin?

Programs need to create awareness about need for changes in lifestyle in all age groups of t population. At the same time, studies are required determine the attitudes, beliefs and knowledge related to cardiovascular disease risk factors. Different communities, different cultural and

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socio-economic groups, reflect varying attitudes towards the disease, and programs should be developed according to the findings of studies that determine these attitudes.

Ideally, changes in attitudes and behavior should begin within the nursing and health professions — higher levels of health in these groups may lead to increased awareness and change in those we seek to teach. In certain health care agencies, programs have already begun to create an awareness of individual fitness levels through the use of various methods of exercise testing. Some of these programs are encouraging behavior change and individual commitments to become involved in personal fitness programs.

Nursing must become involved in the assessment of individual communities to determine the basis upon which preventive programs can be developed. This assessment can also be done in the work community by nurses in the occupational health field. Within this setting, management can be made aware of the economic benefits of preventive programs to their organization in educating and reducing risk factors among their employees.

There are many approaches related to the prevention of cardiovascular disease which may be included in occupational health programs. Group meetings to promote awareness of life style and risk factors, "fitness" breaks during work hours, individual assessments of employees to identify those at risk, individual counselling; these are only a few. The occupational health nurse may also become involved in secondary prevention and rehabilitation of those with cardiac disease among the work force.

Change related to reducing risk factors of an environmental nature involves alteration in beliefs, attitudes and learned patterns — no small task. Programs related to other health concerns have experienced limited success rates in fostering real change in lifestyles. Evidence to this fact is the recent expression of the Addiction Research Foundation of Ontario that there is an increasing incidence of alcoholic problems despite extensive preventive education. There is a challenge to community nursing to become involved in the exploration of effective methods for creating awareness and change in behavior. There is a need for nurses to expand their skills and modify their role to provide leadership in community education. This means that we need to become competent in applying principles related to learning and change for all age groups. We need to teach the individual to take the initiative to make his own discoveries about his health, and to encourage groups to become involved in a new learning experience. Our expertise in content is not enough to provide meaningful learning experiences and change behavior toward more healthful living. The recent concept of social marketing may provide a framework for the assessment and development of preventive programs.[9] Development of such programs will take time and deserves the attention of nurses knowledgable in cardiovascular nursing at the local, provincial and national levels.

Preventive programs related to cardiovascular disease are in an evolutionary stage. Nurses involved in cardiology, whether in primary or secondary health services, may touch many current community programs in an attempt to integrate preventive teaching into the whole community and to involve all age groups. Such programs provide an opportunity for team work among nurses and other professionals in various areas. Nursing input in preventive cardiology is necessary in schools, parent groups, service groups, church groups and exercise programs. These are but a few of the areas for beginning awareness.

Formal programming, using films, dialogue and discussion, seems to have an effect on awareness and result in some modification of lifestyles. Films such as *Celebration,* or *The Canadian Home Fitness Test,* are two examples. More structured programs are in the developmental stages. They are created to reach individuals of specific risk levels, and are designed for active participation and informational dissemination. It is too soon to know the results of these types of programs but not too soon for nurses to become involved.

Heart disease has reached epidemic proportions in western society. Recognition of its affect on the health and economy of the nation can no longer go unheeded. Priorities in health care must include the study and development of programs to eradicate this disease. There are major roles for nurses in the stimulation, development and implementation of preventive programs. Are we willing to accept the challenge?

Betty Oka (R.N., Vancouver General Hospital School of Nursing; B.Sc.N., University of Washington; M.N., Montana State University) is a clinical specialist in cardiovascular nursing. She is presently employed as Nursing Consultant-Supervisor with the Niagara Regional Health Unit in Thorold, Ontario.

Changes....

The dynamics involved in the development of the cardiovascular system are among the most complex and crucial of the human body. The constant stress to which the body is exposed necessitates compensation by all body systems. All too often in our care, we concentrate on those changes that are inadequate, inappropriate or absent.

That's why in this, the first of a three-par series on the cardiovascular system in health and disease, the emphasis is o prevention.

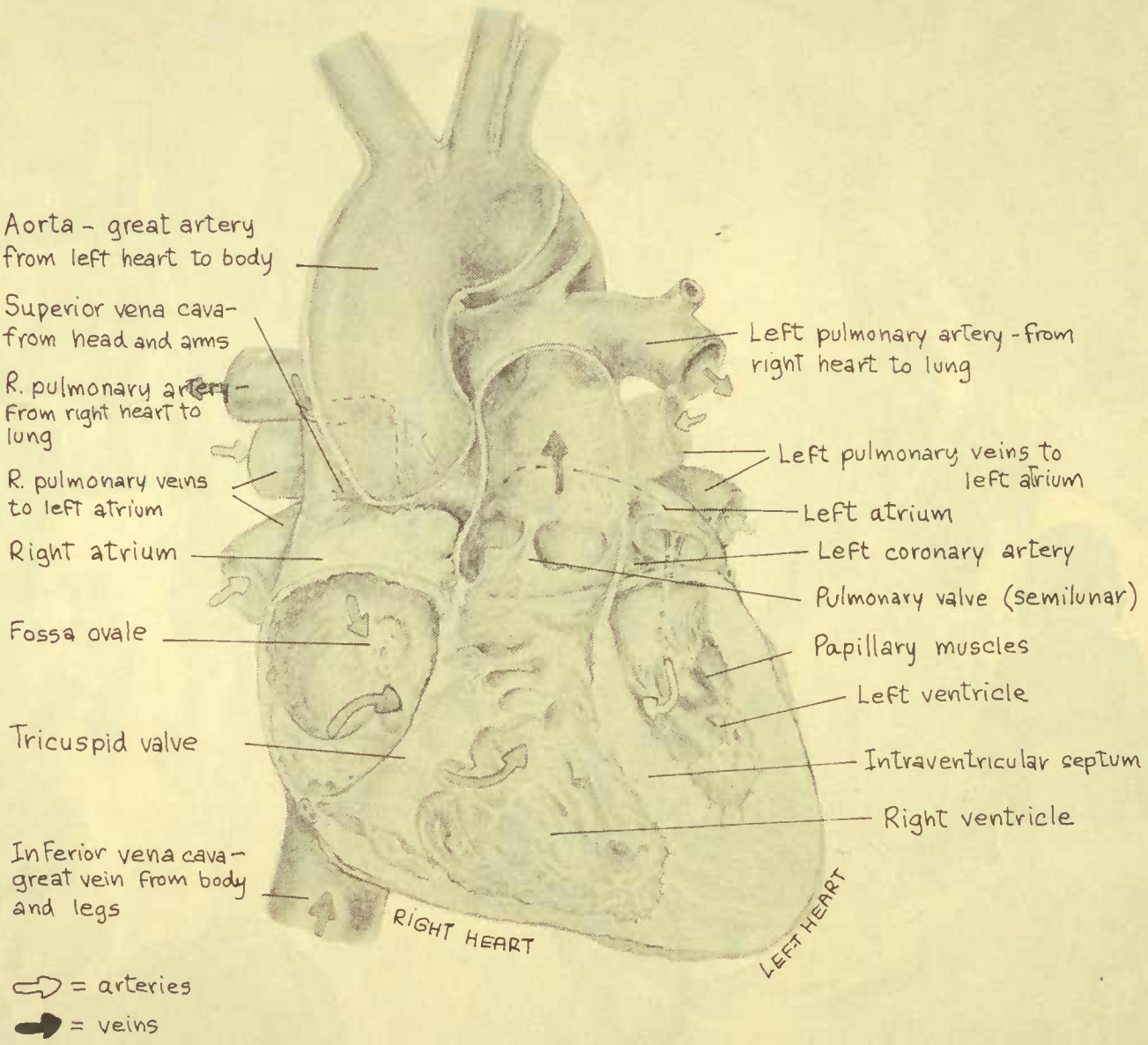




Penny Jessop

Anatomic and Physiologic Dynamics

Shirley Mohyudden, the artist who supplied these special illustrations for the cardiovascular series is a registered nurse living in Brossard, Quebec. Her work has previously appeared in the June issue of The Canadian Nurse. These drawings are adapted from medical illustrations by Leon Schlossberg.



Cross section



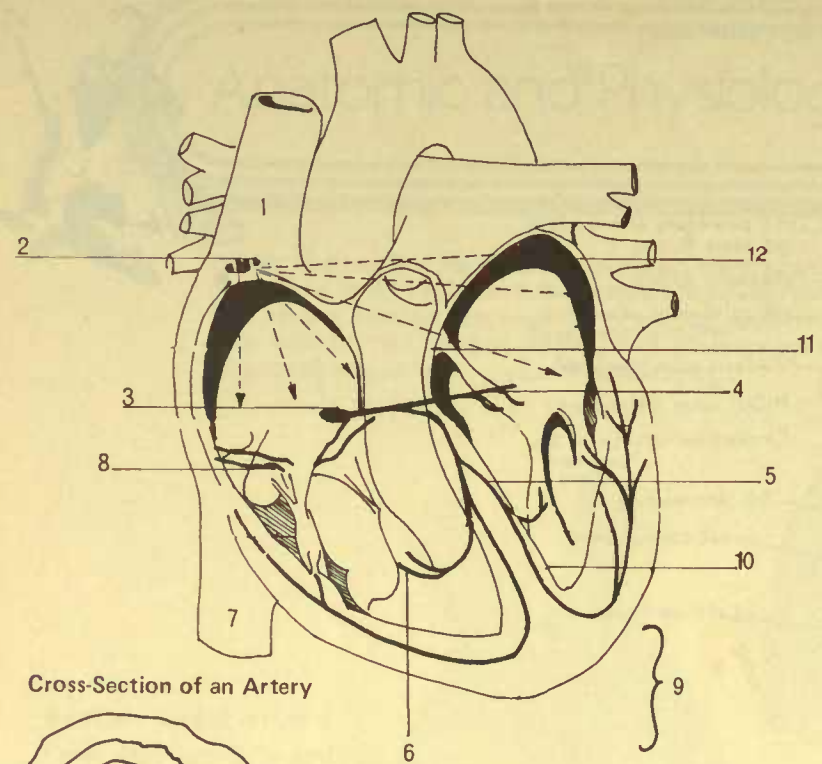
Innominate artery
Left carotid artery
Left subclavian artery
Aorta–great artery from left heart to body
Superior vena cava–great vein from head and arms
Right pulmonary artery From right heart to lung
Right pulmonary veins From right lung to left heart
Aortic valve (semilunar)
Right atrium
Tricuspid valve
Small cardiac vein
Right coronary artery
Right ventricle
Inferior vena cava–great vein from body and legs
Left pulmonary artery–from right heart to lung
Pulmonary artery
Left pulmonary veins–From left lung to left heart
Pulmonary valve (semilunar)
Mitral valve (bicuspid)
Circumflex branch of the coronary artery
Ant. descending
Great cardiac vein
Left ventricle
RIGHT HEART
LEFT HEART

Anterior

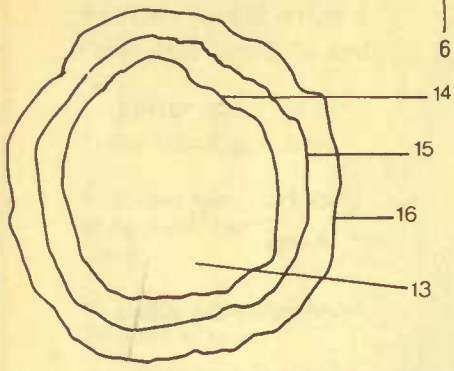
Intercostal arteries
Left pulmonary artery
Left pulmonary veins
Left posterior ventricular vein
L. ventricle
Aorta
Right pulmonary artery
Superior vena cava
Right pulmonary veins
Left atrium
Right atrium
Coronary artery
Inferior vena cava
Posterior descending coronary artery
Middle cardiac
Right ventricle
LEFT HEART
RIGHT HEART

Posterior

Anatomic and Physiologic Dynamics



Cross-Section of an Artery



Penny Jessop (R.N., St. Mary's School of Nursing, Kitchener, Ontario; B.Sc.N., University of Ottawa) has extensive experience in nursing education. She has been Nurse Clinician in the intensive care unit of the Kitchener-Waterloo Hospital and in the Department of Ambulatory Care, Hamilton, Ontario. At present she is the director of public education for the Ontario Heart Foundation.

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This unit is designed for self-learning and review. You may even wish to keep it at hand as you refer to other cardiovascular topics. From the column at the right, select the word or phrase you feel best completes the statement.

Correct answers appear on page 33.

Complete the following using the word choices at the right.

- Properties of the myocardium include _____ (1), _____ (2), and _____ (3). Because of one of these, namely _____ (4), some cells may depolarize independently thus causing _____ (5) _____ or beats arising from outside the _____ (6) _____.
- An inseparable relationship exists between cardiac function and form whether in regards to cellular activity or the cardiovascular system as a whole.
- Cardiac development begins in the _____ (7) _____. The major structural differences existing prenatally are _____ (8), _____ (9), _____ (10), _____ and _____ (11). At birth, closure of the _____ (12) _____ between the atria, and the _____ (13) _____ connecting the pulmonary artery to the _____ (14) enables completion of the circulatory circuit through the lungs. This closure is thought to be directly related to _____ (15) level in the blood.
- The heart chambers after birth are normally interconnected only by _____ (16) _____ and _____ (17) also know as the _____ (18) valve. As the blood enters the heart and passes through the _____ (19) chambers then enters the lungs via _____ (20) _____, the actual gaseous exchange occurs in the _____ (21) layer of the lung.
- On returning to the left _____ (22), blood is passed to the _____ (23) _____ then through the _____ (24) _____ to the _____ (25).

Label according to the diagrams at left.

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____
11 _____
12 _____
13 _____
14 _____
15 _____
16 _____

The volume of blood put out in one minute divided by the heart rate per minute is known as _____ (26). This latter function is directly related to _____ (27), _____ (28) and _____ (29). Similarly, these three factors are closely associated with the blood pressure level as it surges into the arterial system from the strongest of the four chambers — the left ventricle.

The mechanical contracting-relaxing action of the heart is controlled by specialized nerve cells within the myocardium responding to the _____ (30) nervous system. The impulse is generated at the _____ (31), radiates to reach the _____ (32), then down the _____ (33) which branches to form a single Bundle of His Branch, and then divides into _____ (34) _____ (35) Bundle Branches. Small _____ (36) carry the impulse toward the apex.

At cell level, an electrical potential is set up by the exchange of ions of _____ (37) and _____ (38) across the cell wall. This electrical process is known as _____ (39) and _____ (40). Stimulation of the _____ (41) nerve acts to inhibit impulse conduction.

Normally, depolarization of the ventricles takes _____ (42) seconds and occurs 60-90 times per minute. This is followed by repolarization of the ventricles, mechanical contraction and a resting or _____ (43). Throughout the complete cycle, each cell maintains its _____ (44). Electrocardiographic representation of this phenomenon could be briefly outlined as follows:

P wave = _____ (45) _____ (46) = passage of the impulse from the natural pacemaker to the AV node

_____ (47) _____ (48) = ventricular

T Wave = repolarization of the _____ (49) _____.

- Changes in circulatory system structure and functions are not only directly measurable in the cardiac cycles, but also in other major body functions. For example, impaired renal activity may result in _____ (50) _____ (51) _____ (52) cerebral arteriosclerosis may manifest as _____ (53), _____ (54), _____ (55), _____ (56), _____ (57).

- The development of arteriosclerosis is, in part, a natural change with age. However, from continued studies such as that in Framingham, Massachusetts we realize many factors related to the environment can likewise influence health status. Can you identify these risk factors: _____ (58), _____ (59), _____ (60), _____ (61), _____ (62), _____ (63), _____ (64), and _____ (65).

- What changes are you prepared to make in your life style, in teaching for primary prevention, and working toward secondary prevention?

More on "**Changes**" to follow.

junctional block
SA Node
rhythmicity
AV Node
automaticity
irritability
ectopic beats
torpidity
stress
aorta
tricuspid valve
common bundle
left ventricle
umbilical vein
sinoatrial node
semilunar valve
first trimester
nutrition
pericardial sac
heart rate
tonicity
umbilical arteries
bicuspid valve
right
stroke volume
autonomic
ductus arteriosis
foramen ovale
pulmonary arteries
atrium
blood volume
atrioventricular junction
mitral
prostaglandins
parenchymal
left
lack of exercise
smoking
obesity
stroke
QRS complex
Purkinje fibres
electrolyte imbalance
depolarization
vagus
recessive
P-R interval
3-4.2
ventricles
mental confusion
repolarization
syncope
potassium
ocular
hypertension
congestive heart failure
sodium
age
atrial depolarization
electrical potential
refractory period
cerebral haemorrhage
transient ischemic attacks
heredity
hyperlipidemia
0.04-0.09



Head to Toe

A straightforward approach to patient assessment and charting

Lynda Ford

Where to begin? Often a nurse's observation and charting skills are tried severely when there is too much going on — and all at once. A tangle of tubes, a fortress of machines, bottles, trays, charts, parades of medical staff, even the cleaning man's ever present mop — all present barriers to a clear and thorough nursing assessment of the patient who lies in the middle of it all...

It doesn't much matter where a nurse works — methodical observation and evaluation of a patient's state of health is as important in an outpatient department as it is in an intensive care unit. The confusion of a busy hospital setting can distract the nurse from signs that tell of what is going on with Mr. Jones. Whether Mr. Jones has just had his appendix out or has undergone an aorto-coronary bypass graft, the signs will be there to let us know whether or not all is well.

Education and experience teaches a nurse what to look for relative to a patient's particular condition. Sometimes, though, it's difficult to pinpoint what is wrong, whether it's because Mr. Jones finds it difficult to verbalize, or because he's confused or unconscious.

Mr. Jones is much more than a bandaged abdomen or a heart. The "whole patient" concept is pretty easy to tuck away with other mementos from our schooling years as something that just isn't practical when the ward is humming with activity. But there are times when finding out what is wrong with Mr. Jones demands a methodical and total nursing assessment.

Working as a relief nurse in critical care areas at Vancouver General Hospital, I was pleased to discover that a concise, thorough and uniform method of patient assessment was in use. Not only did it allow me to grasp a more complete idea of what Mr. Jones was up to, but I could see clearly from previous charting how he had been progressing in the past.

There are probably valuable guidelines in use in other centers for complete patient assessment. Certainly, the 'Head to Toe' check is nothing new — there is nothing in it that nurses aren't already familiar with. But the use of a systematic check for assessment and charting is a departure from the usual haphazard collection of signs that we often see.

I would like to thank the nursing staff of the Cardio-Thoracic Unit at the Vancouver General Hospital for sharing their 'Head to Toe' check with us. I hope you find it helpful.

The 'Head to Toe' check is one part of a set of guidelines drawn up for use in the post-operative heart unit, Willow Cardio-Thoracic Unit, V.G.H. The method certainly has possibilities for application in other areas, although such a complete check is in many cases unnecessary. It can be used in conjunction with the monitoring of the patients vital signs, fluid balance and test results. At the Cardio-Thoracic Unit, where the twelve hour shift is in effect, a complete 'Head to Toe' check is done at the beginning, middle, and end of each shift. The complete check is charted at the beginning of the shift, and then, only as changes occur. Any changes in the patient's condition can therefore be seen and reported quickly, as they are thoroughly recorded at least once a shift. And when Mr. Jones reaches the convalescent stage of his illness, the complete check may be altered as indicated by his condition.

The check involves looking at the patient systematically, observing and charting all that there is to be seen. It forms the basis for informed and total patient care from a nursing and medical standpoint. Treatment hinges on accurate observation. It would take a text to describe all that a nurse might discover in her examination of the patient and so I have concentrated on the method of observation itself — observation that follows a methodical pattern — from head... to toe.

Head to Toe Check Head to Toe Check Head to Toe Check Head to Toe Check

Head
Observe and chart:

1 the patient's level of consciousness, any improvement or deterioration
- his level of orientation, if awake
- his mood, frame of mind or behavior, if applicable — is he unusually restless, upset, or quiet?
- his complaints of headache — how does he describe it?
- his response to verbal, tactile or painful stimuli
- his response to simple commands — is he able to follow them?

2 the patient's pupillary reaction — note the size, equality and reflex action of the patient's pupils to light.

3 the patient's limb movement as it pertains to neurological function — the strength, equality of movement, and sensation perceived by the patient. Test hand grasps for strength and equality, leg strength by the "push and pull" of both feet.

4 the patient's color — generally, is he pale, jaundiced, cyanosed, or is his color good? Note especially his lips, earlobes, and nailbeds.

Neck and Chest
Observe and chart:

1 the rate, depth and quality of the patient's respirations
- the movement of the diaphragm and thoracic cage
- any assymetric movement of the chest
- any indrawing, tracheal tug, restlessness, shortness of breath, nasal flaring, splinting of respirations

2 breath sounds (listen with a stethoscope to evaluate the breath sounds of anterior, lateral, and posterior chest — apices, midzones, and bases.) Compare sides. Describe what you are hearing — are the breath sounds good, slightly diminished, diminished or absent? Does the chest sound clear, moist, dry, wheezy, or bronchial.

3 for respirator patients — note the size of the endotracheal tube or tracheostomy tube — check for inflation of the cuff, note the type of ventilator, oxygen concentration, whether the patient is on automatic or self trigger, the tidal volume, pressure, chest expansion and "control".

4 for patients on oxygen — note the oxygen concentration, flow rate, and type of mask in use.

5 note any chest incisions, dressings, chest tubes, the color and amount of drainage, and type of drainage system in use.

6 the patient's complaints of chest pain — how does he describe its location and intensity?

7 the rate, quality, and rhythm of the patient's heart rate.

Abdomen
Observe and Chart:

1 is the patient's abdomen soft, taut, rounded, distended, flat, firm, or board-like?

2 does he have bowel sounds — strong, fleeting, occasional, or absent?

3 describe any abdominal incisions, dressings or drainage tubes and the type of drainage present.

4 does the patient complain of abdominal pain? How does he describe it?

Extremities
Observe and Chart:

1 the strength and equality of dorsalis pedis and posterior tibialis pulses — if absent, check the popliteal and femoral pulses.

2 note the color, warmth and strength of the patient's arms, legs and feet.

3 note any dressings or bandages on the patient's legs and arms, as well as the color and quality of any drainage.

4 does the patient describe any pains or cramps in his arms or legs?

5 describe the patient's coordination or gait, if applicable.

Skin
Observe and chart:

1 the texture of the patient's skin — is it dry or clammy, cool or hot to touch.

2 are there any areas of skin breakdown? Check especially coccyx, back of the head, heels and elbows. Describe them.

Equipment
Observe and Chart:

1 Intravenous Infusions — what solution is running, the rate of infusion, medication added, the appearance of the site — is the tubing patent?
- describe the CVP line as above

2 is the arterial line patent? — does the patient complain of pain in conjunction with the site? If the arterial line is in his arm, is there any blanching of the arm involved?

3 ECG — record the tracing and take a new tracing for any change in rate and rhythm.

4 Catheter — note the size, patency of the tube, the color and volume of urine draining.

5 Nasogastric tube — note the size, patency of the tube, color and volume of drainage-check for location to be sure it is in the stomach.

You can see for yourself that there is nothing in the 'Head to Toe' check that you haven't heard before. For a 'Head to Toe' assessment of Mr. Jones, see next month's issue of *The Canadian Nurse*.

Childhood Cardiac Anomalies: A Review

Judith Hendry and Judith Mitton.

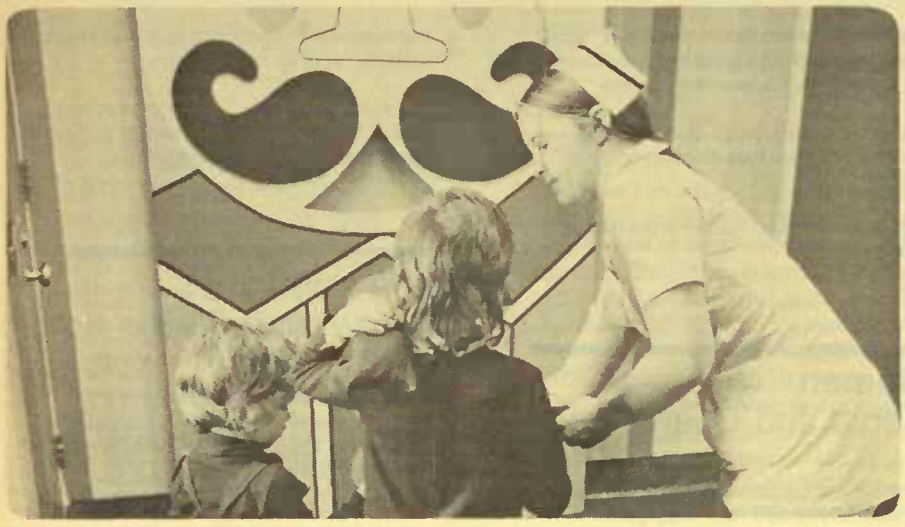


Photo courtesy Sunnybrook Medical Centre

In approximately six out of every 1000 children who are born, the development of that crucial organ — the heart — differs significantly from the normal.[1] How a particular cardiac anomaly is treated depends on the type of defect, degree of severity and the child's individual response. The authors describe some of the most commonly encountered cardiac anomalies and look at ways nurses can help families of these children adjust to the responsibility of helping them to live well-rounded and satisfying lives.

Using a broad knowledge base, the nurse is i a key position to assist in the identification c infants and children with cardiac defects. Some of the signs and symptoms of congenital heart problems which the nurse may assess in children are summarized in Table 1. Many of these signs may occur simultaneously. Thus, it is often the combination of several signs that is indicativ of congenital heart disease. The discussion that follows describes some specific cardia anomalies and their associated symptoms and treatment.

Patent Ductus Arteriosus

In the fetus, the ductus arteriosus is the norma passageway between the pulmonary artery and the aorta which allows blood to by-pas the lungs. This ductus usually closes within th first few months after birth. However, in pater ductus arteriosus (P.D.A.), the ductus remain open and oxygenated blood is shunted fron the aorta, an area of higher pressure, to the pulmonary circulation and is recirculated to th lungs. This may lead to increased vascular pressure in the pulmonary system and diminished blood flow in the aorta resulting i overloading of the left ventricle.

Infants with P.D.A. usually have a continuous machinery-like murmur in the le intraclavicular area. If the shunt is small, a systolic murmur may be the only finding.[2] These infants are usually acyanotic unless there are other associated defects.

Spontaneous closure of the P.D.A. is rare after infancy. When the defect occurs in isolation it is ligated via surgical interventior However, if it occurs with other associated defects it may not be surgically corrected sinc it allows an increase in blood supply to the lungs.



Septal Defects

A ventricular septal defect (V.S.D.) is an abnormal opening in the septum that separates the right and left ventricles.[3] Small V.S.D.'s may be asymptomatic and even close spontaneously. However, large defects may cause considerable shunting of blood during systole, usually from the left to the right side. This occurs as a result of higher pressure in the left ventricle.

Since cyanosis is not usually present, this abnormally is frequently not discovered at birth. A harsh murmur which may be heard between the third and fourth left intercostal spaces is often the only clinical finding.

There may be similar abnormal openings between the right and left atria called atrial septal defects (A.S.D.). In these defects, the shunting of blood results in recirculation of oxygenated blood to the lungs and increased volume load in the right ventricle. Poor tissue oxygenation may lead to growth retardation. Cyanosis is not usually present but may result from left-sided heart failure or pulmonary hypertension.

In most cases, the prognosis for children with operable defects is good. When open heart surgery is indicated, the smaller defects may be sutured closed and larger defects may be closed with a type of synthetic patch.

Coarctation of the Aorta

A coarctation of the aorta is a constriction of the lumen of the aorta, most frequently found in the region of the aortic arch either pre or post ligamentum ductus arteriosus.[4] Children with this defect have high blood pressure in the upper extremities with related symptoms such as headaches, frequent epistaxis, flushed face and bounding radial pulses. The lower extremities have lower blood pressure and may be cold with weak dorsalis pedis, posterior tibialis and femoral pulses. The child may complain of pain in the legs upon prolonged exertion.

The prognosis varies with the location of the coarctation and the development of adequate collateral circulation. Surgical intervention involves resection of the affected segment of aorta. Depending upon the length of the coarctation, the intervention may take the form of either anastomosis of the unaffected aortic walls, or insertion of an aortic graft.

Tetralogy of Fallot

This defect includes four associated anomalies: a ventricular septal defect; hypertrophy of the right ventricular wall; pulmonary stenosis; and dextraposition of the aorta. Blood entering the right ventricle cannot be totally accommodated by the stenosed pulmonary artery. Some of this blood may flow through the V.S.D. and into the aorta causing a mixture of oxygenated and unoxygenated blood in the aorta.

Seventy-five per cent of children with Tetralogy of Fallot (T.O.F.) are cyanotic by one year of age and at an early stage develop clubbing.* The infants may have hypoxic attacks in which vigorous crying may lead to dyspnea and severe cyanosis. Placing the child on his abdomen in a kneechest position may help to relieve the dyspneic attacks. When the child starts walking, he may spontaneously prefer the squatting position to relieve dyspnea.

Total correction of the defects may be done in the first few years of life. However, palliative surgical procedures may be completed prior to total correction to increase the flow of blood to the lungs. Examples of these include the Blalock-Taussig procedure, an anastomosis of the left subclavian artery to the pulmonary artery, and the Potts and Waterston procedures, each of which involves an anastomosis of the aorta and the pulmonary artery. These procedures result in an increase of blood flow to the lungs, improving exercise tolerance and reducing cyanosis.

* Clubbing-Rounding of the fingers especially the thumbnails with thickening and shininess of the terminal phalanges.

Table I

Signs and Symptoms of Congenital Heart Disease

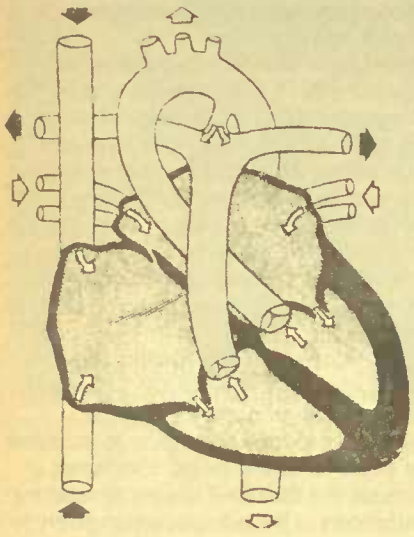
In Infancy
- anoxic attacks
- choking spells
- dehydration
- diaphoresis
- exhaustion
- failure to thrive
- feeding problems

In Childhood
- alterations in blood pressure
- clubbing
- decreased exercise tolerance
- poor physical development
- squatting (seen in children with Tetralogy of Fallot)

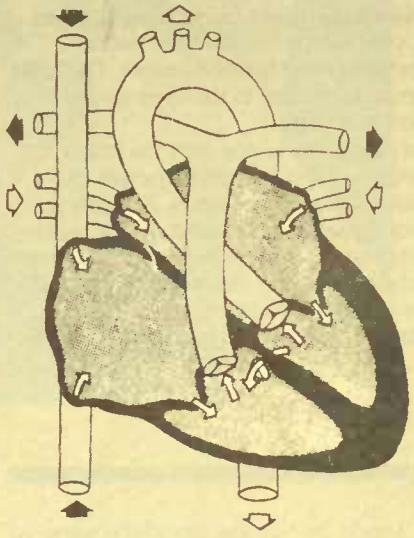
General
- alterations in pulse rate and rhythm
- alterations in respiratory rate, depth and rhythm
- anorexia
- coughing
- cyanosis
- dyspnea
- fatigue
- flaring nostrils
- growth retardation
- heart murmur or thrill
- indrawing
- irritability
- pallor
- recurrent respiratory infections
- restlessness
- shortness of breath on exertion



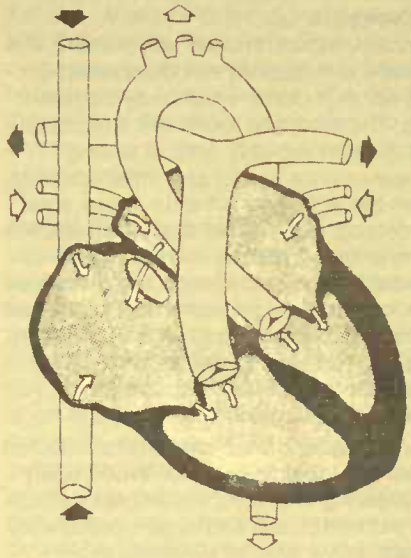
Patent ductus arteriosus

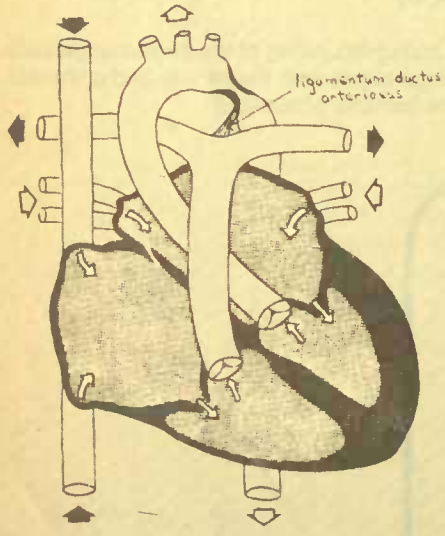


Ventricular septal defect

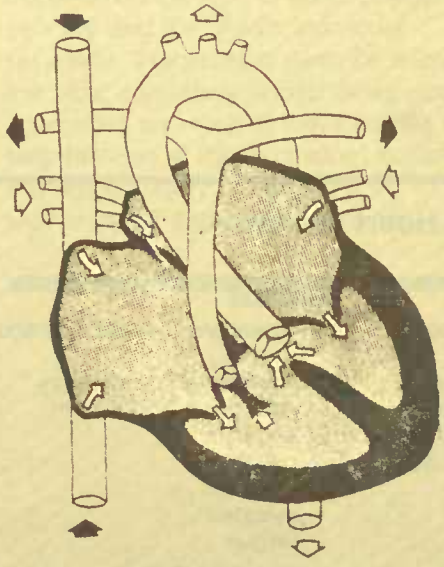


Atrial septal defect

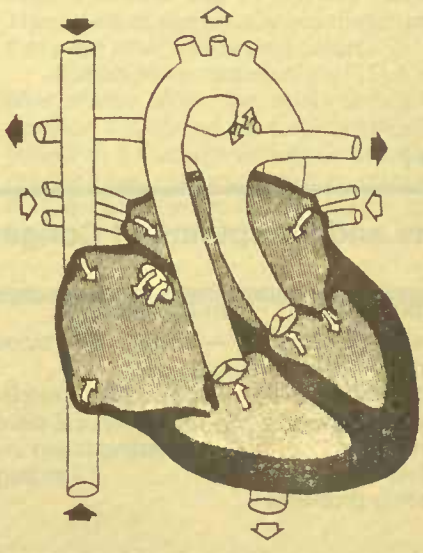




Coarctation of the aorta



Tetralogy of Fallot



Complete transposition of the great vessels

Reprinted with permission from the illustrations of Congenital Heart Anomalies in *Ross Clinical Education Aid No. 7,* Ross Laboratories, Columbus, Ohio.

Children with congenital heart disease: some parental concerns and problems

Transposition of the Great Vessels

In transposition of the great vessels (T.G.V.), the developing pulmonary artery and aorta fail to rotate during the first few weeks of fetal life.[5] The aorta arises from the right ventricle instead of the left and the pulmonary artery arises from the left ventricle instead of the right. Thus oxygenated blood is recirculated to the lungs and unoxygenated blood is recirculated to the body. The condition is incompatible with life unless there are other defects which allow the mixing of oxygenated and unoxygenated blood, such as a V.S.D., A.S.D., or P.D.A.

Infants with T.G.V. become cyanotic soon after birth. They may have difficulty with their feedings, sucking eagerly at first but soon becoming dyspneic and exhausted.

Treatment may consist of creating an atrial septal defect by means of a balloon catheter during cardiac catheterization.[6] A catheter is passed through the foramen ovale, inflated, and pulled back to tear a larger passageway for mixing of blood. Complete redirection of the flow of blood may be achieved by the Mustard procedure. In this surgery, oxygenated blood from the pulmonary veins is directed to the right ventricle by excising the atrial wall. This oxygenated blood is then pumped to the aorta and to the systemic circulation. Unoxygenated blood from the vena cava is tunneled through a surgically created pericardial pouch into the left ventricle. From here the unoxygenated blood will be pumped to the lungs.[7] The prognosis of infants having T.G.V. has greatly improved since the advent of these procedures.

The nurse who understands the degree of stress that diagnosis of heart disease in their child may provoke in parents, can help them to cope with their feelings and, indirectly, do a great deal to improve the quality of life of the child with a cardiac defect.

Since the heart is considered the most crucial organ of the body and interference with its integrity tends to be regarded as potentially life-threatening, it is only natural that heart disease of any nature provokes anxiety in both parents and their families. When it is a child who has heart disease, the stress to parents may be profound and exacerbated by guilt feelings and fears.

Parents of a child with a congenital heart defect, or indeed any chronic condition, need support and practical guidance to maintain a lifestyle that is healthy for the sick child, for the parents and for other members of the family. This kind of guidance can only be successfully given and utilized if those working with the sick child function as a team and include the parents as members of that team. Since the parents must assume the responsibility of caring for their child at home, carrying out a medical regimen designed to foster his optimal growth and development, effective health teaching is of utmost importance. Most parents do everything they can to provide the best possible care for their child. When expected results are not attained, it is more often due to a lack of effective health teaching than to a lack of parental concern.

In an effort to find out more about the specific health education needs of these families, the authors conducted a number of interviews with parents of children who were hospitalized because of cardiac anomalies. They found that mothers of these children shared many common concerns about their role as parents of children with cardiac defects and were experiencing many similar problems in looking after these children. In these interviews, the mothers often expressed a need for recognition of the job they had done and were doing in maintaining their child's health status. Their self-image received a blow when they had to deal with the fact that their child was not physically perfect and they needed reassurance from the nurse that what they were doing was in the best interests of their child.

Mothers also expressed the desire to be given information about their child without having to ask for it all the time. This voluntary information-giving seemed to indicate to them that the health personnel recognized them as a part of the health team.

While all mothers expressed satisfaction with their doctors, stating that they were kept well informed about their child's condition and prognosis, significantly, they did not see nurses in the same light. One mother wondered if nurses saw her as a "nuisance". She said that few nurses volunteered information about what they were doing for her child and she had to ask for clarification, adding, "After awhile I start to feel guilty asking". (This mother made her comments shortly after her child had undergone



corrective cardiac surgery and it is probable that her perception of the situation was influenced by a high level of anxiety.) When teaching parents about their child's condition, it would appear that nurses must consider the effects of anxiety on parental comprehension of explanations and use repetition and reinforcement judiciously.

Discipline and limit-setting for the cardiac child is another area of concern to mothers. They have been advised by health personnel to treat the child normally, to set the same limits and follow the same discipline practices as they would for any other child. This often proves difficult for a number of parents. They worry about the effects of discipline on a child with a cardiac defect and often, they feel guilty about the anomaly and try to compensate by giving in to the child's every whim. This approach frequently leads to fretful and demanding children and increases the parents' uncertainty about their abilities to care for their child appropriately.

Parents who do set firm guidelines for their children also express concern that their methods may not be completely appropriate. When these children require hospitalization, mothers often comment that it is difficult to maintain the discipline practices carried out at home. Their statements appear to indicate that they are concerned about the nurse's perceptions of their abilities in this aspect of parenting.

Tied to the area of limit-setting is the related aspect of overprotection. Parents often feel a certain reluctance in allowing a cardiac child to seek his own level of activity and may curtail activities more than actually necessary. Glaser describes parents of these children as being in a "chronic state of anxious watchfulness".[8] Striking the delicate balance between allowing independent action and providing sufficient disciplinary guidance is a difficult task for any parent. It seems to be even more problematic for the parents of a child with congenital heart disease because of their concern about the interaction of discipline and the child's physical condition. Health personnel should be aware of the dilemma parents often see themselves in and encourage open discussion of their concerns.

The presence of a child with a cardiac defect puts varying strains on all family members. Parents sometimes find that they focus the greater part of their attentions on this child to the detriment of their other children. Siblings may not understand why the cardiac child receives extra attention and special or different privileges. They may feel neglected or develop behavioral manifestations to draw attention to themselves. On the other hand, they become very protective of the child and assume an unrealistic responsibility for him.

The feeling of responsibility associated with caring for a child with a cardiac defect often causes parents to ignore their own needs and may lead to increased frustration and marital tension. "A person or a couple who is emotionally and physically exhausted cannot continue to give to others in a healthy way. Many parents... feel guilty about using time or other resources to meet their own needs, and they need help in understanding the vital importance to the family of their doing just that."[9]

Clearly, caring for a child with a cardiac defect is a complex problem that goes far beyond the hospital walls. Recognition of some of the difficulties shared by these families in their home environment can help nurses to find ways of making parents effective and responsible members of the health team by giving them the support and encouragement they need.

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Quick Change
Quiz

The following mini-quiz is designed to test your familiarity with the cardiovascular system and its problems.

Mark true (T) or false (F)

1 Intracardiac pressure is normally the highest in the left atrium. ☐

2 Genetic counselling is essential for all parents of children with congenital cardiac anomalies. ☐

3 Prophyllactic penicillin is a long-range form of management in rheumatic heart disease. ☐

4 Newborns with pulmonary atresia are almost entirely dependent on patent ductus for pulmonary blood flow. ☐

5 Slight slowing of heart rhythm may be evident on E.C.G. during inspiration. ☐

6 Arteriosclerosis is a condition of the elderly. ☐

7 The most reliable evidence of streptococcal infection capable of causing rheumatic fever, is a throat culture. ☐

Answers

1 F — highest in the left ventricle prior to systemic circulation.

2 F — although this may help, it is not common to see these disorders frequently repeated.

3 T — Group A Streptocci may be harboured, or transmitted by others to the sensitive individual.

4 T — the patent ductus offers an alternate route.

5 T — due to chest expansion, increased O_2 level, and possible vagal stimulation.

6 F — it is progressive with age beginning at an early age; thus, teaching primary prevention to children is an essential role of the nurse.

7 F — These bacteria exist normally in some individuals, particularly children. The best assay is an antibody titer (ASO).

CHANGES

Anatomic and Physiologic Dynamics Answers

Diagrams

1 superior vena cava
2 sinoatrial (SA) node
3 atrioventricular (AV) node
4 posterior division — left bundle branch
5 anterior division — left bundle branch
6 Purkinje fibres
7 inferior vena cava
8 tricuspid valve
9 apex
10 interventricular septum
11 interatrial septum
12 left atrium
13 lumen
14 tunica intima
15 tunica media
16 tunica adventitia

Text

1 *rhythmicity*
2 automaticity
3 irritability
4 automaticity
5 ectopic beats
6 SA node
7 first trimester
8 umbilical arteries
9 umbilical vein
10 ductus arteriosis
11 foramen ovale
12 foramen ovale
13 ductus arteriosis
14 aorta
15 prostaglandin
16 tricuspid valve
17 bicuspid valve
18 mitral
19 right
20 pulmonary arteries
21 parenchymal
22 atrium
23 left ventricle
24 semilunar valve
25 aorta
26 stroke volume
27 heart rate
28 tonicity
29 blood volume
30 autonomic
31 sinoatrial node
32 atrioventricular junction
33 common bundle
34 left
35 right
36 Purkinje fibres
37 potassium
38 sodium
39 depolarization
40 repolarization
41 vagus
42 0.04 — 0.09
43 refractory
44 electrical potential
45 atrial depolarization
46 P-R interval
47 QRS complex
48 depolarization
49 ventricles
50 congestive heart failure
51 hypertension
52 electrolyte imbalance
53 mental confusion
54 syncope
55 cerebral haemorrhage
56 transient ischemic attacks
57 stroke
58 heredity
59 obesity
60 lack of exercise
61 stress
62 smoking
63 age
64 hypertension
65 *nutrition*

A New Look at Cardiac Catheterization Equipment

Sandra LeFort

The Hospital for Sick Children in Toronto is known worldwide for its research, diagnostic techniques and treatment of many childhood health problems. HSC has kept abreast of new scientific and medical developments in the field of pediatrics and indeed, has often been the forerunner of medical advances in childhood diseases.

Congenital heart disease has been one focus of intensive research at the Hospital for Sick Children. In the diagnosis of heart ailments in the young, cardiac catheterization has been a vital tool since it was first introduced to Canada in 1946 by Dr. John D. Keith, then HSC's Chief of Cardiology. Since that time, there have been amazing advances both in technology and in the surgical treatment of heart problems.

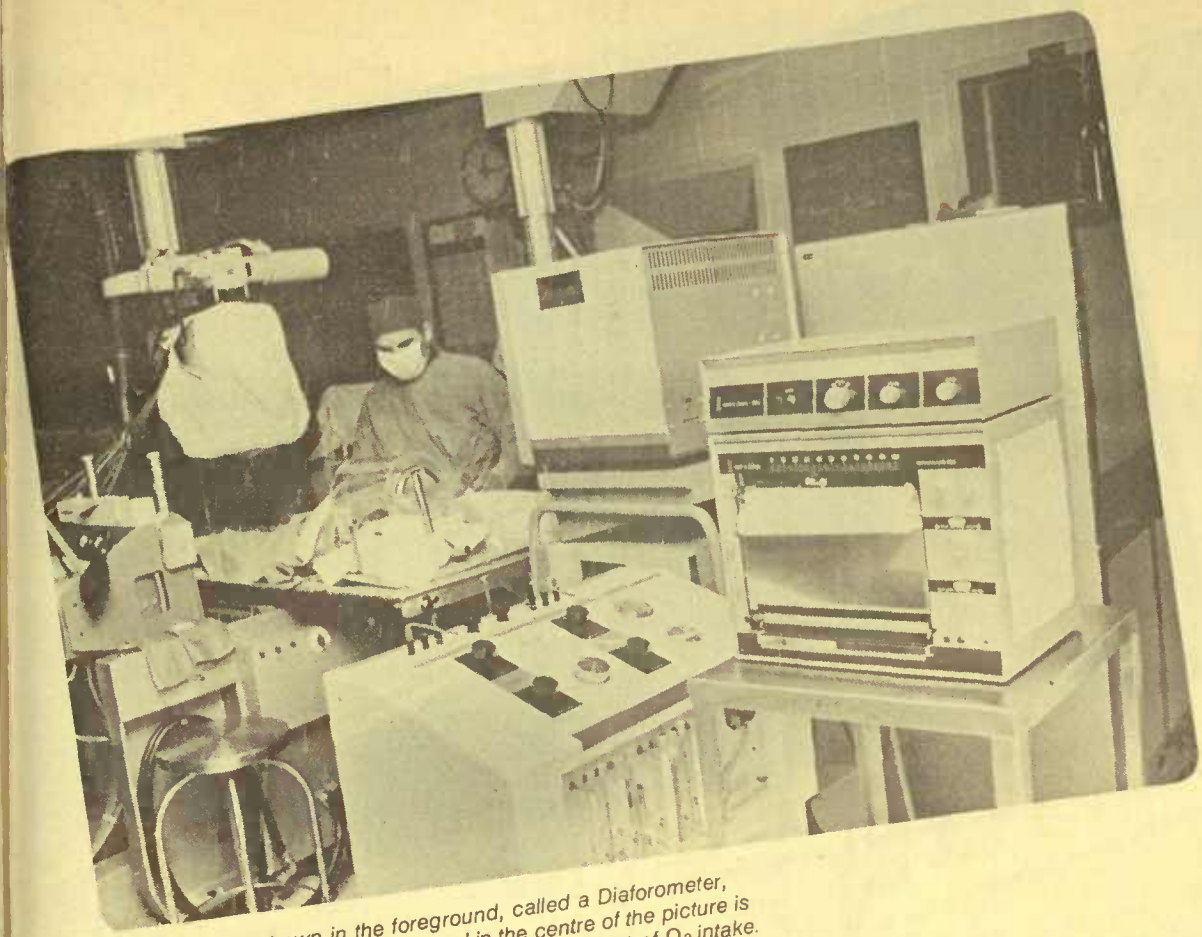
HSC has the largest patient load of any children's cardiac centre in North America and performs an average of 700 to 800 cardiac catheterizations a year in two laboratories. Earlier this year, HSC purchased new equipment for one of its cardiac catheterization labs with a $300,000 grant from the Variety Club of Ontario.

At *The Canadian Nurse,* we were interested in finding out more about this equipment to see what advantages it offers. Recently, I visited the Hospital for Sick Children to talk to Dr. Peter Olley, Chief, Section of Laboratories, Division of Cardiology. As we talked, I learned a great deal about the general 'workings' of the



Nurse Elaine Grady measures O_2 saturation in blood by use of an oximeter.

Photos courtesy of Lou Scaglione, Department of Photography, Hospital for Sick Children.



The equipment shown in the foreground, called a Diaforometer, measures O_2 consumption. The hood in the centre of the picture is placed over the patient's face to regulate the amount of O_2 intake.

equipment and its operation. Dr. Olley explained that the conventional catheterization equipment has one X ray tube and one image intensifier which are in fixed positions. To obtain different views of the heart, the patient must be rotated at different angles while strapped to the table. A more recent advance involved a bi-plane system which had a double set of X ray tubes and image intensifiers — both in fixed positions. This enabled horizontal and vertical pictures to be taken simultaneously and displayed on two television screens. Angled pictures, however, still necessitated the rotation of the patient.

The newest equipment, which is the first of its kind in North America, is now in full operation at HSC. It also has a double set of X ray tubes and image intensifiers. However, while one plane (horizontal) is fixed, the other plane (vertical) is attached to a U-arm (see Figure I) which can be rotated around the patient. Thus in most cases, the patient remains flat on his back during the procedure.

To illustrate the operation of the equipment, Dr. Olley showed me the new lab where a cardiac catheterization was in progress. A young boy was being catheterized to evaluate the efficiency of his artifical mitral

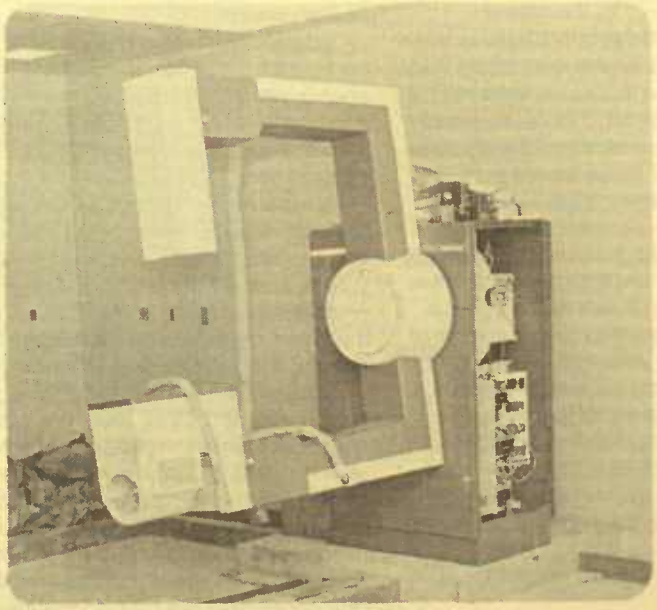


Figure 1 Before completion of the laboratory, this picture of the U-arm was taken showing the image intensifier on the top and the X ray tube on the bottom.



Nurse Pat Grande calibrates the pressures in the four heart chambers. Note the double television screens which enable horizontal and vertical views of the heart to be seen simultaneously.

valve which had been surgically inserted a year ago. The patient was drowsy but awake throughout the procedure, and the two T.V. screens simultaneously showed the workings of his heart.

At this point, Dr. Olley stated that there are two major advantages of the new equipment over the old. One is the increased detail in the pictures taken of the heart. This is especially important for the precise location of anomalies in complex congenital heart disease.

The other main advantage lies in the increased safety to the patient: there is less possibility of catheter displacement especially in the newborn, since rotation of the patient is not usually necessary; fewer radio-opaque iodine injections are required since two sets of pictures are obtained with every injection of dye; and, there is some reduction in the amount of radiation given to the patient.

In reviewing with me the reasons for performing cardiac catheterization, Dr. Olley pointed out that there are many diagnostic tests which can be done during the procedure. Depending on the heart problem, some or all of the following tests may be performed:

— measurement of O_2 content of the blood in the heart chambers which can help in locating septal defects

— establishing the presence of and the measurement of left-to-right and right-to-left shunts within the heart by the injection of a green dye

— measurement of the patient's O_2 consumption

— measurement of intracardiac blood pressure which, when compared to normal values, helps in the diagnosis of stenotic valves and pulmonary hypertension.

— assessment of the conduction system of the heart by recording the electrical activity directly from the Bundle of His

— assessment of the heart muscle as a pump.

These and other tests are usually conducted while the patient is at rest. They can also be done to test the heart during exercise by having the patient do isometric exercises or by infusing certain drugs, eg. Isuprel, Propanolol (Inderal), and Priscoline. Depending on the number of tests done, the procedure can take from 45 minutes up to four or five hours — a long time for any patient, child or adult.

After these preliminary tests are completed, the angiograms are done by the injection of radio-opaque dye into the heart



Nurse Pat Grande gives O_2 to a patient. Image intensifier 'A' is attached to a U- arm and can be rotated.

Dr. Dorothy Radford inserts a catheter into the femoral artery.

chambers. Pictures of the heart taken on 35mm film give a permanent record of structural defects of the heart, volume of the heart chambers, and general heart function.

Treatment of newborns with some types of cyanotic congenital heart disease may be performed during a cardiac catheterization. For example, recent studies done at the Hospital for Sick Children have shown that the ductus arteriosus in normal babies is extremely sensitive to E-type prostaglandins which cause the ductus to relax. In some forms of cyanotic heart disease, the ductus is the only opening that allows the mixing of oxygenated and unoxygenated blood. During a cardiac catheterization, doctors are now able to give an infusion of E-type prostaglandins which results in the relaxation of the ductus, thereby increasing the amount of oxygenated blood getting to the lungs. Although this is only a temporary measure (lasting for a few days at the most), it gives the health team time to consider permanent treatment.

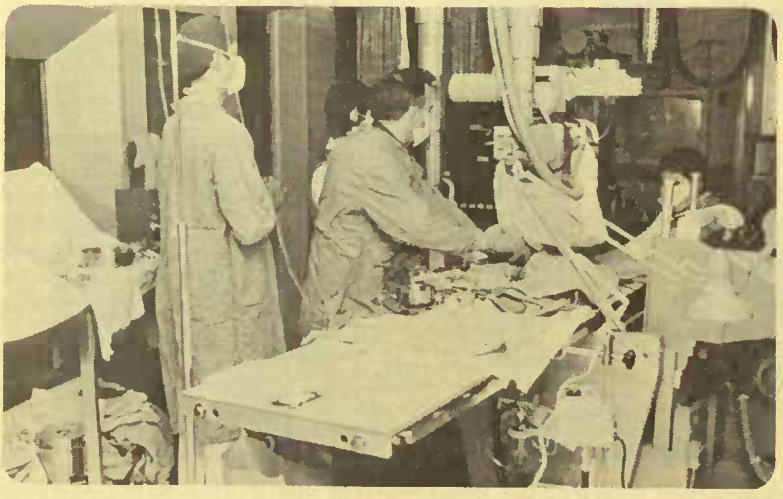
In children with transposition of the great arteries (T.G.A.), a catheter with a ballon on the end can be used to create a large



While Dr. Dorothy Radford inserts the catheter, Nurse Pat Grande comforts and reassures the young patient.

atrial septal defect so that the mixing of oxygenated and unoxygenated blood is increased.

To conclude, I found the new equipment most impressive. Although not drastically different from older models, it seems to be a better, safer way to perform cardiac catheterizations and certainly appears to give a more detailed picture of that most vital organ — the heart. The number of children undergoing this diagnostic procedure would seem to demand the use of the best equipment available. A more accurate picture of cardiac anomalies prior to surgery gives the surgeon more complete information about the child's condition before the operation. And, as Dr. Olley states, the effect of using the new equipment will hopefully be seen in improved surgical results for children with cardiac problems.



During a cardiac catnetization, Dr. Peter Olley (center) and others observe the position of the catheter on a television screen.

We at The Canadian Nurse extend thanks to The Hospital for Sick Children for the opportunity to spend some time visiting their cardiac catheterization laboratories. Special thanks goes to Dr. Peter Olley for the time and effort spent in helping us with this article.

Clinical Wordsearch no.2

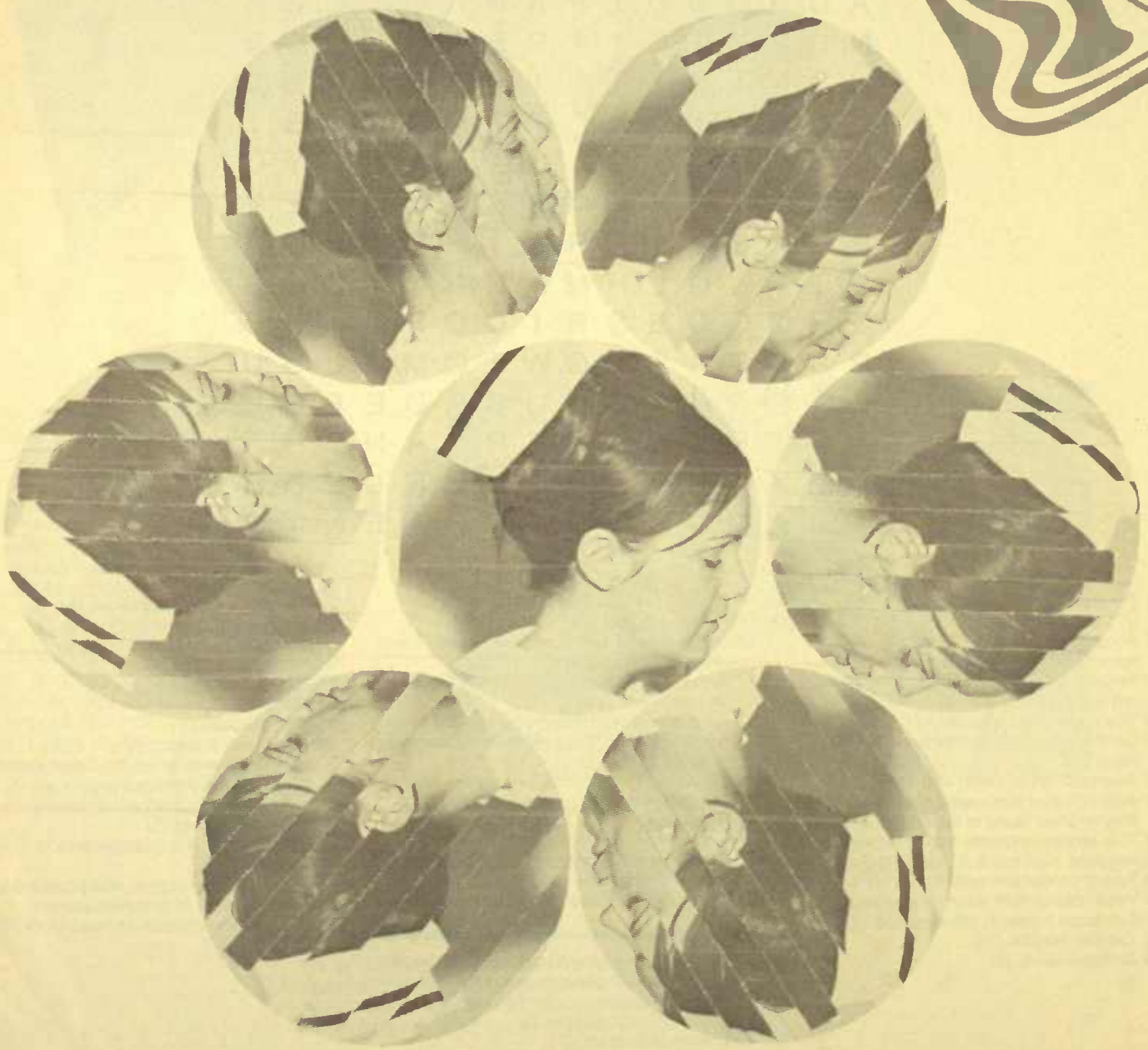
Solve the clues. The bracketed number indicates the number of letters in the word or words in the answer. Then find the words in the accompanying puzzle. The words are in all directions — vertically, horizontally, diagonally, and backwards. Circle the letters of each word found. The letters are often used more than once so do not obliterate them. Look for the longest words first. When you find all the words, the letters remaining unscramble to form a hidden answer. (Answers page 53).

S E I R A L L I P A C C L O T D
R P N L A I R E T R A B S H O C
A U H O T D I P A R A O I O G A
N L S Y I R I A P E R S L P C R
U S N I G T I L T S R B O N E D
L E S L T M A C T T S I N U S I
I I D C I I O L U A G P R N Y O
M H I T H A D M L S E L U N E V
E R A C V I E R A I P H O N O A
S T A N G L H M A N R I T O G S
E R O O O E S R I C O B D I Q C
B D X T A S L O W T O M I L U U
E I S R E L D N U B R D E F R L
N Y T E L E M E T R Y A N T D A
S M Y O C A R D I U M N L E E R
A D A M S N O I T C R A F N I R

1 Foxglove derivative, stimulates vagus nerve. *(7)*
2 A four chambered muscular organ responsible for circulation of blood. *(5)*
3 Pertaining to those vessels carrying bright red oxygenated blood. *(8)*
4 The pulse in tachycardia. *(5)*
5 On the way back, between capillaries and veins. *(6)*
6 A companion of sweat and tears. *(5)*
7 Although their walls are only one cell thick, they're often found in beds. *(11)*
8 This arrythmia results from interference in impulses from the S.A. node. *(5)*
9 Part of conduction system, not her's. *(3) (6)*
10 Valve joining right atrium and ventricle. *(9)*
11 Sub-acute bacterial inflammation. *(12)*
12 Cardiac muscle. *(10)*
13 Bicuspid valve. *(6)*
14 The beat is not usually 4/4 time. *(5)*
15 Phone-in E.K.G. *(9)*
16 That period of the cardiac cycle when the heart muscle contracts. *(7)*
17 Artery commonly used in blood pressure measurement. *(8)*
18 A mass of cardiac muscle fibres lying on the right lower part of the interatrial septum of the heart. *(1, 1, 4)*
19 Pertaining to the circulatory system. *(14)*
20 Device used in B/P measurement. *(16)*
21 What captured criminals and some patients have in common. *(6)*
22 Extremely rapid, irregular heart beat which usually precipitates cardiac standstill. *(12)*
23 Type of valve preventing backflow in veins. *(9)*
24 Thrombus. *(4)*
25 Because of the nature and location of the pain associated with oesophageal reflux, it can be said to mimic on___ cardiac pain. *(7)*
26 Lactic Dehydrogenase. *(3)*
27 Electrocardiogram. *(3)*
28 Serum glutamic oxaloacetic transaminase. *(4)*
29 Partial thromboplastin time. *(3)*
30 Erythrocyte sedimentation rate. *(3)*
31 Characteristic pulse in bradycardia. *(4)*
32 Hora somni. *(2)*
33 Pro re nata *(3)*
34 Nil per os *(3)*
35 *Quater in die* *(3)*
36 Shortness of breath *(3)*
37 a cardiogram in which the heart sounds produced are indicated graphically *(5)*
38 the physical or mechanical restoration of damaged tissues *(6)*
39 development of a localized area of ischemic necrosis *(10)*
40 Stokes___ syndrome, characterized by sudden attack of unconsciousness, frequently accompanies heart block *(5)*

Mary L.S. Vachon

Enforced Proximity to stress



The author, a nurse and sociologist, dons her other three hats to describe what nurses can do to cope with the stress they encounter on-the-job every day. In this paper, prepared for the 1976 CNA annual meeting and convention, she speaks as a consultant to staff in a cancer hospital, consultant to cancer patients and their families and, finally, as a consumer.

in the Client Environment

There was a time when we were trained as nurses to deal with our emotional response to the disease, disfigurement and death that surround us in our daily work. We were taught to believe that the "good nurse" did not have "bad feelings." She did not quake and tremble when at age eighteen she washed the genitals of a man her father's age. She did not panic when the alarm rang on her patient in the ICU. Nor did she want to run from the room when a patient she cared for postoperatively suddenly and fully conscious started to hemorrhage from all orifices. Most important, she did not break down and cry when a patient that she had tenderly cared for died.

Oh yes, those were the good old days when we put on our professional manner with our uniform. We were secure in the knowledge that we could cope; we were unflappable because we had to be. We knew that a good nurse was cool, calm and competent. Certainly we were good nurses then — we must have been — we sure tried to be.

In those days not only were we secure in our roles but the patients also knew their roles. They knew enough to be passive and compliant. We knew what we were doing and they didn't question us. They were patients, not clients or consumers and they didn't hassle us about patients' rights, husbands in our sacrosanct delivery rooms or death with dignity. Family members knew their place, too. When we told them it upset their children when they came to visit, they stayed away. They waited outside the ICU without continually wanting to see how the patient was doing. Most of all they did what they were told .

Why have things changed so much? Why are issues we resolved years ago suddenly problems? Why are we suddenly asking ourselves these questions?

— Why do we have problems with stress in our interactions with patients?
— What are our biggest problems and how do we cope with them?
— What can we do to resolve some of our difficulties?

Let us start with the question of why we are under stress. Haven't we always been close to clients and their stress? The answer is, no, not in the same way we are today. Technological advances often require us to be either right at the bedside of a critically ill patient or within quick reach. This is not like the old days when a dying patient rang his bell and you could simply shut it off or ignore it. Now you are there immediately — your adrenalin starts working, your pulse and B.P. increase. As you work to save a life, this stress is palpable.

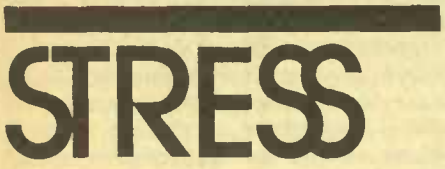
If you are a real nurse you are not simply saving a life. You have come to know this patient and you recognize the stress his illness presents for him and his family. Your struggle is for a life that means something to you. The loss of that life is a loss for you. If you feel this loss, you can take just so many like it before you quit or become callous, preaching the gospel of non-involvement — "Don't let it get to you, it's all in a day's work."

Technological changes and enforced proximity to stress also create other problems. Often our new knowledge only makes it possible to prolong the dying process. Helping individuals and their families during this time is extremely difficult. It has many rewards but the stress is tremendous. Certainly there is satisfaction when you have been able to give excellent palliative care — but there is a sense of loss and a feeling of "How can you die after all I've done for you." It's not logical but feelings aren't — let's realize that. It was much easier in the days when we didn't acknowledge such feelings, but it's much more real now.

Another reason for our stress has to do with the pressure on us to live up to our role as professionals. Society expects that now that it pays us decent wages, we had better perform at a higher level and be more accountable than we have been heretofore. The client is no longer a passive recipient of whatever we wish to dispense. Consumers know that our salaries are paid out of their tax dollars and they are demanding our help in meeting their health needs and making changes in the health care system .

Enforced proximity to demanding consumers is a major source of stress for many nurses today. Learning how to recognize and deal with this stress is a challenge which is extremely threatening to us because it hits us where it hurts — in our image as competent professionals.

I believe the biggest problem we face is ourselves. Before making any changes to



alleviate stress in the client environment we must, as nurses, come to terms with our own identity. To recognize ourselves as competent professionals requires a genuine sense of self-esteem that is sadly lacking in many of today's nurses. Sure we feel secure when we put on a uniform and exert power over helpless patients and family members. That's not what I'm talking about. I mean the genuine sense of competence and self-esteem that comes from keeping abreast of changes in our profession and community. ...that respects, acknowledges and utilizes the changes brought about through the Women's Movement. ...that is not threatened when challenged by a client with innovative ideas and/or a higher level of education than our own. ...that does not retreat into passive-aggressive games with medical colleagues and administration but makes demands and, more important, seeks and accepts responsibility.

All of this is made more difficult by recent budget cutbacks that have threatened our jobs. More than one nurse who has made an innovative suggestion has been warned: "Don't forget the door swings both ways. We don't have to put up with any complaints from you because people are begging to take your job." Some of the best nurses I know have received this treatment. They have responded, not with anger and assertiveness, but with the passive-helpless attitude that has become all too common in nurses today.

It is socialization that has encouraged women to respond in this way. Also, many of us who enter nursing are very idealistic people, prone to develop depression. When we are able to help clients and to achieve recognition we are pleased. But when people suffer and die, our self-esteem is threatened, or our ideas are challenged or ignored, our depression surfaces and we become passive and helpless and/or develop psychosomatic symptoms. This understanding of ourselves is crucial to our resolution of the difficulties we encounter in the client environment.

What can we do to surmount these difficulties? Previously, when we were frustrated and under stress we could change jobs. In today's economic climate this is no longer possible. Therefore, we have to develop new coping strategies.

Some of us, as individuals, are able to



improve our work situation by developing expanded roles, assuming new responsibilities and achieving increased visibility and credibility. This works on an individual basis but accomplishes little for the rest of the profession.

Group action is often the best approach to a major problem. Through group meetings nurses can identify their needs and develop constructive approaches to their problems. The nurses at Princess Margaret Hospital in Toronto, for example, were having difficulty dealing with dying patients. They decided to ask for outside help. Gradually, working with the nurses, we were able to conceptualize their difficulty as follows:

1 The nurses had been socialized to know that the "good nurse" never has "bad" feelings. As a result they were working in relative isolation, each one feeling she was the only "bad" nurse, the only one who at times felt angry, depressed, frustrated, helpless and hopeless.

2 This led to mistrust. The nurses were hesitant to be open with one another for fear of criticism and, as a result, there was very little operative group support.

3 The lack of understanding and acceptance of their own feelings led to a lack understanding and acceptance of the feelinç of patients. In addition, the nurses were divided about their feelings regarding the impact of cancer and the effectiveness of treatment. Their attitudes ranged from: "Wh do they bother taking treatment, they're onl going to die anyway" to "Why should peop be so upset just because they have cancer. Conflict was compounded when patients die because the hospital was seen as an activ treatment center and not a place where peopl came to die.

4 Because of lack of insight into their situation, nurses were unable to function in their accepted role of maintaining smooth interpersonal relationships and this led to anxiety which the omnipotent and omniscie physician was expected to resolve.

5 When the physician failed to perform th expected magic and intervene to improve th situation, problems erupted. Staff discord increased and patient care deteriorated.

6 These problems all became particular acute when patients in whom the staff had significant personal investment were dying. I these situations the feelings of individual nurses were aroused. They were unable to share these feelings with one another and therefore had trouble dealing with the patien They expected the doctor to help but he wa often impotent, because of his own difficultie with dying patients. The nurses could not understand this because of the power and competence they projected onto the doctor.

"As the nurses became aware of and bega to accept their own feelings of anger, depression, frustration, hopelessness and helplessness they were able to share them with one another and receive support. This then freed them to use their natural empathy t accept and understand these same feelings i patients without feeling that they had to forc patients to either repress or ignore their feelings in order for the expected smoother interpersonal relationships to occur.

Gradually, the nurses became able at least to entertain the idea that perhaps the

nysician might be experiencing some of the ame feelings they had. At this point they were ble to decrease their expectation of support m the doctors. They began to feel that it ight even be possible, through the support ey gained from their own group, to be able to ffer some help to the physicians in the grief ey faced when patients died or were dying. his increased insight and also gave the urses the initiative to approach physicians ith the problems they observed and to ggest alternative approaches.

In view of the socialization process of omen, such independence, initiative and ggressiveness are noteworthy changes for urses. At times, their expanding roles created ifficulty because they had considerable mbivalence about accepting the sponsibility that went with assuming itiative. It was much easier to criticize the octor than to take the responsibility for itiating change.

By being willing to look at their own elings and share them with their co-workers e nurses gained new insights and strengths milar perhaps to those gained in some

STRESS

onsciousness-raising groups. This enabled em not only to increase their understanding f patients but also to expand their capacity to ssume initiative and leadership in patient are. Relationships with physicians then nproved because the nurses were able to ealize that the doctors were also having ifficulty in caring for dying patients. As ressures from the nurses on the physicians ecreased, the doctors became much more illing to discuss treatment programs and to sten to the nurses' suggestions. This was not lways easy for the nurses because of the sponsibility inherent in assuming initiative nd some nurses were sufficiently ambivalent bout this new role that they retreated to their rmer passivity and the security of the status uo. For those who were willing to change, owever, the rewards were great."[2]

This is one example of the effectiveness f group effort. This is where our strength as nurses lies. To cope with our enforced proximity to stress in the client environment, we must work together to gain insight into the stress and evolve more effective coping mechanisms. We must stop pulling against one another and utilize the idealism and energy of our younger members, the maturity and competence of the middle aged and the wisdom of the older nurses among us.

Working together we may get somewhere, struggling alone we will fall prey to the stress diseases endemic in society today.

Mary Vachon (R.N., B.S.N., Boston University, M.A., University of Toronto) is in a unique position to help health workers and patients cope with their "feelings" as people.

As Mental Health Consultant, Community Resources Service, at the Clarke Institute of Psychiatry, she was the principal investigator in a study of the newly bereaved which indicated that their needs were not being met by either professionals or the community. This resulted in the establishment of a self help program for the recently widowed.

As she describes in this article, her role as Psychiatric Nursing Consultant at the Princess Margaret Hospital also enables her to assist nurses in learning how to assess, cope and deal constructively with the feelings that are expressed by cancer patients. She is a lecturer in the Dept. of Psychiatry, University of Toronto and is also presently working towards a Ph.D. in Sociology at York University, Toronto.

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At Last...



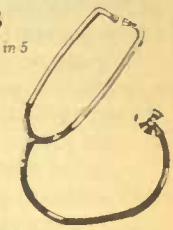
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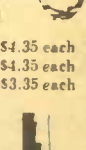
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Mary Berglund: Backwoods Nurse



I have three treasures which I hold and keep.
The first is mercy; the second is economy;
The third is daring not to be ahead of others.
From mercy comes courage; from economy comes generosity;
From humility comes leadership.

The Tao Te Ching,
Chapter 67

Ingrid Bergstrom

In any society there are people who are attracted to banners and causes — some good, some bad; some effective and others not so effective. Then there's another group — people who are aware of those causes but don't ever get involved. Instead, they quietly seek to fulfil themselves by living out what they feel to be productive lives. Many of them do it well. The most successful all seem to have one thing in common — a flair for getting on with it.

Mary Berglund is a person like that. She's a registered nurse and lives in Ignace, Ontario, about 150 miles north of Thunder Bay. I'd heard stories about Mary — how she'd treated people in her home, how she'd hitched rides to make house calls, and how she'd never made a cent for all this work — that she'd considered it all just part of the work of day-to-day living. I was intrigued. Mary sounded like a breath of fresh air so I made arrangements for a visit.

The two and a half hour drive up the Trans Canada highway ended at a flat bare-looking little town, edged in northern pine, with several new motels and a Chinese restaurant on the outskirts. A sign said "Welcome to Ignace." I had arrived. I stopped at a grocery store and asked if anyone knew where Mary Berglund lived. A lady pointed a finger, "Oh sure, Doc Berglund, just turn right at the corner, she lives across the road from the post office in the white house."

There's hardly a soul in Ignace who *hasn't* heard of Mary, much less had to go to her for help of one kind or another. Her reputation has spread as far west as Winnipeg and as far east as the Quebec border.

I knocked on the door and a vigorous, croaky voice hollered "Come on in..." I was invited to "park it on a kitchen chair while she got us some 'dregs' she'd been keeping warm since breakfast". Great dregs.

I was surprised at her appearance. Physically, she stands about 5 foot nothing and looks like everybody's idea of grandma. Somehow, I'd been expecting a tall, thin, authoritarian type of person. Her complexion is clear and rosy colored. Her blue eyes sparkle when she smiles, which is often, and when she speaks she looks you straight in the eye. She has an open casual manner and I could tell right away I was going to like her. She looks about 60. The day I saw her happened to be her 73rd birthday.

We settled back with cigarettes and coffee. How did she get started with this outpost nursing? What did it involve? Well, it seemed she arrived there in 1932 along with her husband Tony. He'd taken a job with the CPR and Ignace was going to be their home. Nine years earlier, Mary had graduated from McKellar School of Nursing in Fort William. Marriage at age 30 had called a halt to her practice, not that she minded much. She was ready to settle down, to raise a family, and for several years, that's just what she did. Mary looked after their three children and Tony worked for the railroad whose shunting area adjoined their small backyard. The only thing that made their life different from small village life today was a definite lack of modern conveniences and the fact that almost everyone around was *very* poor.

In 1939, when war was declared, doctors were needed overseas. Ignace's doctor was among those who went and the little town of 600 found itself with no medical help at all. It wasn't long after that the whole thing started. People came knocking on Mary's kitchen door. Oh, they'd known all along that she was a nurse, but until the doctor left, they'd never had to think about it. In an area subsisting mainly on trapping, hunting and fishing along with some industrial work, there are bound to be accidents. And there were. Fish hooks had to be extracted, cuts sewn up, burns bandaged and broken legs set. They came to the door at any time of the day or night. No one was turned away. Doctor or no doctor, the population continued to grow and Mary found herself delivering babies — in trains, cars, pick-up trucks and on the floors of one-room shacks. She can't even guess how many babies she's delivered — "A lot, for sure."

I ask how she financed herself — most people didn't have too much money then — people in that area still don't. "People paid what they could," she says. Her journals tell of her daily encounters. I thumb through, fascinated.

August 17/49: *Bandaged Indian woman's foot. 25 cents. Set J. Schroeder's foot, broken in fall from roof.*
Total take — 25 cents

August 30/51: *Cinders removed from Indian's eye — gratis. Visited Catrelli baby — OK now. Gave Jorgenson 1 cc penicillin. Foot looks better. Called at Zurukas — infection in Mrs. Z's finger clearing.*
Total take — $6.00

October 13/52: *Accompanied OPP to Dryden Hospital with injured man picked up on highway. Gave Mrs. McCool shot — tetanus. Gave Mr. McCloud 1 cc penicillin.*
Total take — $2.00

There is, it seems, a notation for almost every day from 1940 onwards. I ask about her declaration



of funds received, the "total take" at the end of each day's entry. "Well," she says, "all that money went to buy more bandages, more medicine — people are proud you know, they don't like to take anything for nothing and they gave me what they could afford. Sometimes it was only a dime, other times maybe vegetables from the garden. Tony didn't finance the medicine at all, it had to come out of what I could collect. I kept track of it for the income tax people. The doctors in Dryden — that's our closest hospital, 68 miles away — they were good, I was always in touch with them and they'd advise me in a lot of the cases. I had to have controlled drugs here too — the doctors would sign for them and I'd pick them up. I felt a bit more confident knowing that they trusted me to that extent; they just told me to use my own discretion. I've had to administer morphine, heroin, stuff like that — even with penicillin you know, you take a chance if the patient turns out to have a bad reaction. What else could I do? There wasn't anybody else to help. Nothing like that ever happened though — no bad reactions. I guess I been pretty lucky..."

Over and over again, she mentions the fact that she's been very lucky — I venture the opinion that perhaps luck didn't have so much to do with it as hard work. Why did she choose to take on this responsibility when so many others would have said 'I've got a husband and three kids to raise, I just don't have the time?'

Her answer is honest and touching. "Well, you know, I took the Florence Nightingale pledge at nursing school. If you take it, you gotta mean it. I didn't have a choice, it was something I had to do. That's all." She pauses and stirs the supper on the stove again, stares into the pot and says softly, "You know that verse, you are thy brother's keeper — well, I believe that. I got the skills and the knowledge, so I use 'em. We're not here for long and you get back what you give out. I *am* a lucky person. I got friends, people care. I consider myself very fortunate."



November 15/54: *L. Jorgenson brought in little Indian girl with scalded feet. Looks good, cut away considerable skin and applied Spectrocin ointment. Bill Gaskin came in with abscessed tooth. Gave pen tabs twice a day and 292's. Bob Potsin came in to have a suture removed from finger. Looks good. Mrs. Fletcher came with her daughter and baby, looking well. Bandaged Mrs. F's foot, cut on sole. Doing well.*
Total take — $7.35 and two lovely cauliflowers

I'd heard that Mary had made as many as 25 house calls in a day — was that true? "Oh yeah, it was easier for me to get around than have them come in all the time. Somebody was always giving me a ride. I never learned to drive, not even a bike so mostly I walked. Had to snowshoe into one place to give an old man his liver shot, did that all one winter. But a lot of the time they'd come to the house. I've seen as many as 40 people here in a day. They even used to sit outside on the grass, waiting their turn. I'd break to get Tony and the kids their meals and then get on with it. "She laughs. She tells me she used to charge $1.00 for a patient at her place, $2.00 for a house call — when she could get it. Her charges remained the same until her retirement four years ago.

She excuses herself to go out and move the sprinkler and I try to imagine the activity that took place in this little kitchen. Her stories fill my mind — the one about the fellow standing on a large oil tanker truck enjoying the summer breeze. He decided to light a cigarette and the inevitable happened. The blast threw him some 35 feet through the air. His friends dragged him across Mary's kitchen floor to her medical office — the family bathroom. They propped him on the toilet seat and Mary went to work. She had a small table set up beside the sink — anyone else usually ended up standing up in the tub or sitting on the edge of it. Lace curtains flapped at the window and African violets lined the sill. She did her work quietly and efficiently.

I remember another story about the fellow who mangled his hand in some machinery and how she had to use her breadboard in the kitchen as the work area because the bathroom was in use.

Mary comes back in, commenting on the garden and the fact that it's growing so well. "Going to have to freeze a lot of stuff this year."

Before we can start talking again there's a knock on the door. One of the little neighbor girls has a large bouquet of lilacs — and a happy birthday wish. Mary is delighted. In her conversation with the child there is no age boundary; they speak as friends rather than youth to aged.

I ask her to tell me some more stories. "Well, I remember the time a fellow got his leg chopped off back up there on the tracks." She nods northwards.

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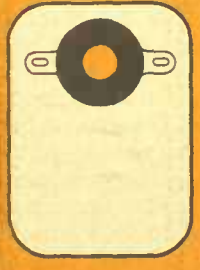
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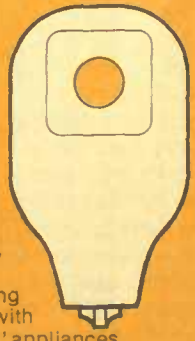
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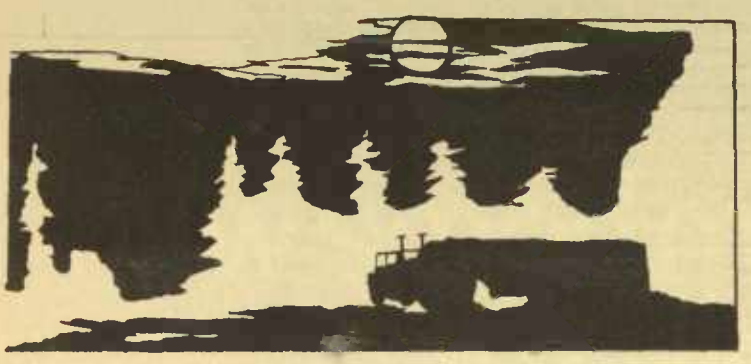
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"I was just doin' up the lunch dishes and Bill comes runnin' in saying 'Mary, come quick and bring your bag!' They were always saying that, hardly ever an explanation — just Mary, come quick and bring your bag. Never knew what to expect. Anyway, this time I went.

Seemed the poor guy had got his leg caught in a coupling and one of the box cars had backed up. Before he could whistle Dixie, his leg from mid-thigh down was gone. Luckily I had some sutures to stop the bleeding. Before I got there they'd made a tourniquet out of his braces. Had some stuff for shock and I got some hot water bottles filled from the house. Made sure the kids had something for supper and arranged for the station master to clear the track from Ignace to Dryden. We got hold of an engine and caboose and whipped him into the Dryden hospital. That was the day I found out they didn't make caboose doors wide enough to get a stretcher on. We had to tie the poor man on and tip him sideways. I stayed in Dryden that night and came back next morning in time to take care of the kids.

On account of that incident, the CPR people had water piped into the house for me. That was a real big thing in those days you know — 1951 it was. Never got a water bill either — even to this day. The railroad's been good to me. Mind you, I stitched up quite a few of their boys too."

Whatever happened to the fellow who lost his leg, Mary?

"Oh, he's livin' up in Kenora now, I hear from him occasionally — says I saved his life. Well, I did what I could, what had to be done." She says it shyly as she butts her cigarette, then looks up and smiles. "Did I tell you, I got some notes from people, if they couldn't come they'd always get hold of some way of lettin' me know they were sick."

She goes over to a drawer and starts rummaging through it. "I didn't save all the notes," she says, "but I remember one day this little kid comes knockin' the door. I went and answered it and he didn't say anything, just handed me this piece of paper. It was written pretty poorly in pencil and it said: "Dere nurs, I am sic, I did not shit for five days. You can come and see me if you want." She lets go a belly laugh and claps her hand over her mouth after saying the four letter word. ("Drinkin', smokin' and spittin', that's me — I don't hold much with cussin'.")

She went down the track a couple of miles to see the patient. Did she get him moving? I ask. "Oh sure, he's still movin', I guess."

Another note she shows me has an almost heart-breaking message. It is written in a childish scrawl from an obviously worried mother of many children. 'Dear Mrs. Berglund' it read, 'do you got anything to make the blood come not to buy another baby. I am sick, it is a month. Please come. Yours truly.'

The story had a happy ending — it was a false alarm. "But you know, the worry that woman went through, it almost made me cry ...."

September 17/52: *Johnny Defoe with a flesh and bone wound. Cut leg with axe, chopping down poplars, axe slipped. Changed bandages. Looking a bit better. Mrs. McCool gave me 48 cents — payment for bandages.*
Total take — 48 cents

September 30/52: *No visitors today — had a rest. Did laundry and ironing and waxed the floors.*

We get talking about school children and I mention I'd heard that she went to a lot of the little one room schools in the area to innoculate the children. Public health nurses, it seems, did not work in the district for several years. "Well, you know the government, take your money and forget all about you," she comments dryly.

Mary had asked doctors in Dryden for the serum and paid for it with her daily "takes." She took on this job herself because, as she says sensibly, "what are you gonna do? Either they got vaccinated or I looked after them next year. It was a whole lot easier to vaccinate them." Again, a lot of the calls were made on foot — but most times she found someone to take her — either in a car or by sled. "People up here help each other — we got to."

She tells about waiting in freezing weather in a broken down car on the side of the highway with Verna E. ... who was about to give birth. Verna's husband who'd been driving went on up the road for help. The interval between contractions became shorter so Mary did the only thing she could. She got out and flagged down a family in a pick-up truck. The somewhat nervous driver moved his wife and children into the back and Mary and Verna crowded into the front. Up the road they picked up Verna's husband and made the trip to Dryden in a little over an hour — not a second too soon either. Verna had a lovely daughter very shortly after.

August 5/56: *Called on Cheryl Young — getting over flu. Given lunch and two packs of cigarettes. Called on Dennis Smyk — given supper and one dozen eggs.*
Take — 2 packs of cigs and 1 dozen eggs

"And we were grateful for that in those days, too!" she comments.

August 15/56: *Dressed Mrs. Hershey's hand, administered 1/4 cc morphine. Dressed G. McNabb's hand. Dressed Mrs. Sockin's foot. Infection has set in. Gave 1 cc penicillin. Pat Johnson paid $10.50 for previous treatment. Was given some blueberries — (beautiful).*
Take — $10.50

August 16/56: *Mrs. Burusky gave me some butter. Cleansed Mr. Nash's cut head and accompanied him to Dryden. Paid $5.00.*
Take — $5.00 and some butter

For 32 years, Mary diagnosed and treated. If there was any illness she felt she couldn't handle on her own, she sought a doctor's advice, but a shadow of fear still lurked in the background. Mary was sure that one day she was going to get caught for practicing medicine without a licence.

In 1972 a letter arrived from the Ontario Medical Association. "I was petrified to open it. I thought, they've finally got me, this is really the end." In fact, the letter contained notificiation that she was going to be honored with a membership in the OMA — the only nurse ever to be awarded the citation. "It was thrilling to think they'd do that for me — a backwoods nurse ...."

She went to Toronto and accepted the award graciously then left again for Ignace. "You never know what's going to happen and I don't like to be away too long."

Nor do Mary's honors end there. She has an Award for Service Medal presented by the Red Cross. Prime Minister Trudeau sent her an appreciative letter and autographed photograph when told of her work in the area. Roland Michener, when he was Governor General, presented her with the St. John's Ambulance pin for outstanding service. The pipeline workers in the Ignace area gave Mary a wrist watch and luggage. The back of the watch is inscribed "To Mary, from the pipeliners." Her scrapbooks are loaded with newspaper articles and letters to the editor about her along with letters of appreciation from CPR officials. In 1969 the Ignace Chapter of the Boy Scouts named her Mother of the Year and to top it all off — she was sponsored by the town of Ignace and named by the Ontario government as one of 25 women honored by that province during International Women's Year. Mary accepts it all with equanimity. "It's nice to know you're appreciated."

She turns to me and asks if I'd like to see how her clinic is coming along. "Sure would," I say. (Her folksiness is catching). We drive over and take a look. The Mary Berglund Clinic is being erected entirely by volunteer labor and seems to be coming along just fine.

"The fellow who dug the foundation, he's an old patient of mine — did it for free. Another patient put up the frame and we got an X-ray machine from the hospital in Dryden. Should be ready soon." Her face seems to glow as she looks it over and I get the feeling this clinic means more to her than anything we've talked about up to now. On the way back, we drive past the firehall. A big sign with "Mary Berglund Clinic Contributions" at the top is nailed to the wall outside. The giant red thermometer indicates that donations are very close to reaching their goal. The money is being used to buy building materials and medical equipment. The clinic was planned by the people of the town of Ignace so that the doctor they have now would not have to work out of his home and and was named in appreciation of Mary's efforts over the past three decades.

We return to the kitchen and talk some more — this "backwoods nurse" and I. The conversation rambles — we talk of the feminist movement and she says, "You can't always have things the way you want, you sometimes have to work around situations and just do what you believe in. Can't say that I hold much with women's lib though, I was always too busy ...."

She moves to the stove to put on the ever-present coffee pot and as she does a line from an article by Sally Kempton in Esquire magazine comes to mind. "Women's liberation is finally only personal. It is hard to fight an enemy who has outposts in your head." A realization dawns that the enemy *has* no outposts in Mary Berglund's head. She has been victorious simply because it has never occurred to her to acknowledge that an enemy exists.

Her journals sit piled on the kitchen table, almost a foot and a half high — mute testimony to 32 years of "doing what had to be done." The clock in the living room chimes seven times and the sky shoots rosy red rays through the window. I've run out of tape but am reluctant to leave, so we talk on.

Mary's been widowed several years now, and all three of her children have married and moved away from home. In 1972 Ignace finally got a resident doctor and "Doc" Berglund retired, although she's still a St. John's Ambulance volunteer. "I get called out maybe once or twice a month." She lives alone in this modest white frame house, along with 108 potted plants — another of her passions.

As we chat she leans back on the kitchen chair and smiles — a sunshine smile. There is a serene vitality about her. Is it passed from countless generations or borne of her own self-knowledge I wonder. Somehow or other, I think it's the latter.

"I've got friends," she says, "I've never had to go hungry or cold — or lonely, so I'm a rich woman in that way — What more could anyone want?" Indeed.

Driving down the highway I remember her answer to the question "Would you do it all again, Mary?" This charming grandmotherly lady with the edge of northern Ontario roughness lit a cigarette and looked me straight in the eye.

"Sure I would, I wouldn't have a choice, would I?"

The author, a former policewoman, world traveller and now freelance writer would just like to say that Mary Berglund, through her words, actions and general air of well-being, taught the author more about living successfully than she'd ever known before — and she is grateful.

Tell Me About Your Picture...

Three-and-a-half year old Tammy appears to be a model patient. Although she was admitted to hospital, in isolation, less than twenty-four hours ago, she sits or lies quietly in the crib. She rarely cries, except when mother comes, but neither does she smile. The nurse who is caring for her says she is a "good" patient. She appears to have adapted well to hospital. But has she?

Figure 1

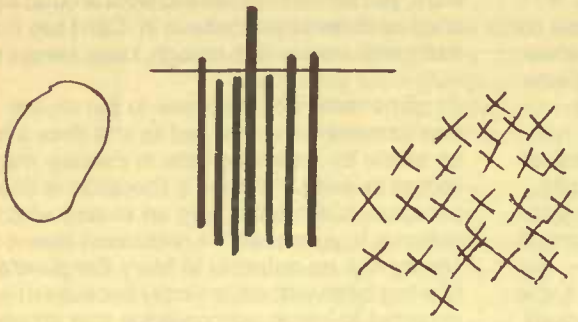
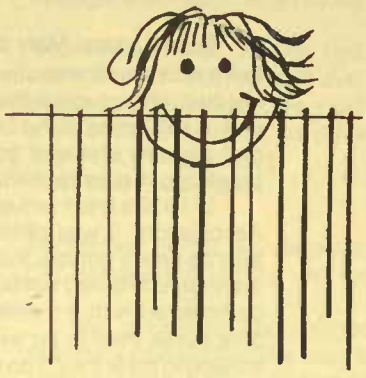


Figure 2



Beverley McCann

The effects of maternal-child separation upon preschool children have been well documented during the past two decades. In children under five, the behavioral changes that may be expected include various stages of separation that are characterized by *protest, despair* and *denial.* According to this description, Tammy should be crying or exhibiting some behavioral indication of protest. Why is it then, that she appears calm, a little shy perhaps, but certainly not visibly disturbed? Are there any behavioral cues that suggest that she too is experiencing stress induced by hospitalization and separation?

Research has shown that denial, repression and projection are the defence mechanisms that preschoolers most often use to reduce anxiety. Overt behavioral manifestations of these feelings include withdrawal and regression.[1] Hospitalized children often exhibit regressive behavior, characterized by a return to an earlier stage of development. For example, four-year old Mark, hospitalized with burns to his left side, who was previously toilet trained and able to feed himself, suddenly becomes incontinent or asks to be fed. Perhaps Tammy has withdrawn, for she hides her eyes when the nurse approaches. *Can nursing intervention modify behavioral manifestations of separation-anxiety or is hospital-induced trauma inevitable?*

Deliberative Approach

I believe that nurses can effectively assist the hospitalized preschooler to cope with the stressful effects of separation induced by hospitalization. They can do this by utilizing a deliberative approach to nursing care. Wiedenbach describes deliberative action as: "interaction directed toward the fulfillment of an explicit purpose and carried out with judgment and understanding of how the other means the behavior he is manifesting, either verbally or non-verbally."[2]

For pediatric nurses, deliberative action implies recognition and interpretation of the child's behavioral cues of anxiety and purposeful formulation of a plan of care that will help him to cope. Such a plan could include the following components:

- Consistency of care
- Involvement of the parent or usual mothering figure
- *Encouraging emotional expression*
- *Consistency of care*

If we believe that total patient care is beneficial for all patients, then for preschool children it is imperative. The literature indicates that separation-anxiety is lessened by a consistent mothering figure, thus providing the child with the security and affection he would normally receive at home. Consistency of care implies the establishment of a trust-relationship between nurse and child over the several

days the nurse cares for the child. Consistent care not only benefits the child, but it provides nurse-satisfaction as well. In experiencing the child's daily progress, a strong bond of affection develops between nurse and child. With an increased opportunity to observe the child, the nurse can better interpret the meaning of the his behavior and thus, more effectively respond to his needs.

- *Parent involvement*

Mothers rooming-in with their hospitalized preschool children may be the ideal means of preventing separation-anxiety , but this solution is often either impossible or impractical. Many mothers work outside the home; some have younger or school-age children at home who need their mother's attention, and many hospitals have no physical arrangements for rooming-in. Parents should, however, be encouraged to visit their child each day. Many parents, like Tammy's mother, express guilt or dismay when they notice that their child cries when they appear or leave. If the nurse explains that their child's crying indicates protest against separation and is a healthier emotional sign than apathy, she can help to reassure parents who are wondering whether it might be better if they did not visit. Mother-substitute figures such as regular babysitters or grandmothers should also be encouraged to visit, especially if mother is working and cannot visit at certain times of the day.

Parents usually take considerable interest in the daily activities of their child, such as meals, sleeping and play. Many of them welcome the opportunity to assist in the care of their child, by feeding or bathing him. The experience of sharing in his care may be emotionally satisfying for both parent and child.

- *Encouraging emotional expression*

The literature strongly supports the concept of allowing children to express their feelings. Vernon declares, "if the child is encouraged and helped to express his troubled feelings to an understanding person, he is often relieved by being able to relate and communicate these feelings.[3] These feelings may be expressed either verbally or non-verbally through play, conversation or general activity. Verbal expressions are more obvious and therefore more easily recognized. The nurse, if she is observant, can also discover many non-verbal expressions of emotion in children. Play materials should be selected not simply because of the diversion they offer, but also because they provide a medium for emotional expression.

When Tammy received paper and crayons for drawing, I said, "Draw me a picture about what it is like to be in the hospital." Quietly and thoughtfully, Tammy went to work. In the center, she drew a series of bars. (See Figure 1). To the left of the bars, she drew a circle. On the right of the bars were rows and rows of "X's."

"Tell me about your picture, Tammy," I asked.

"That's me," she said, pointing to the bars, "but you can't see me because I'm inside."

"Who is this?" I asked, pointing to the round circle on the left.

"Oh, that's Mommy," she said wistfully, indicating the faceless circle, "and that's all the kisses she has for me." She pointed to the rows of "X's." We talked about her picture.

The language of children

Clearly, Tammy was experiencing grief due to parental separation. The faceless mother represented Tammy's repression of her anxiety due to separation. Even her kisses could not penetrate the crib-cage. Children paint what they feel,[4] and the mere expression of this feeling often helps them. The tremendously important role of play in assisting children to express and work through their anxieties has also been well documented and child psychiatrists have been utilizing play therapy to rehabilitate emotionally crippled children for many years.

In the light of the feelings that Tammy had indicated she was experiencing, I decided on a consistent care plan intended to meet some of her needs during this period of stress. After four days of consistently caring for Tammy each day, I once again asked her to draw me a picture. "Draw me a picture of how Tammy is feeling," I asked. Although she was still not allowed out of bed, the tone of this picture was much different (See Figure 2). This time Tammy was in the picture. She drew herself as standing up, looking over the bars of the crib. There was one important difference. This time, Tammy was visible in the picture and she was smiling!

Can a deliberative nursing approach which includes consistency of care, involvement of the parent in the child's care, and the encouragement of emotional expression assist in reducing the adverse effects of hospital-induced separation in young children? I am convinced that it can.



Author Beverley McCann is an Instructor of Pediatric Nursing at Ontario's Fanshawe College School of Nursing, St. Thomas Campus. She prepared this article while completing the clinical nursing component of the Masters program at the University of Western Ontario.

Explaining some of her reasons for writing it, she says, "The experience of hospitalization with its strange surroundings and unfamiliar people can be frightening for any child, especially for one under school-age. However' as a pediatric nurse for several years, and as a mother of three young children, who have experienced hospitalization, I believe that nurses can help to minimize this emotional trauma.

The nurse, in conjunction with the child's family, has the unique opportunity of formulating a plan of care that will significantly reduce the anxiety imposed by separation and illness."

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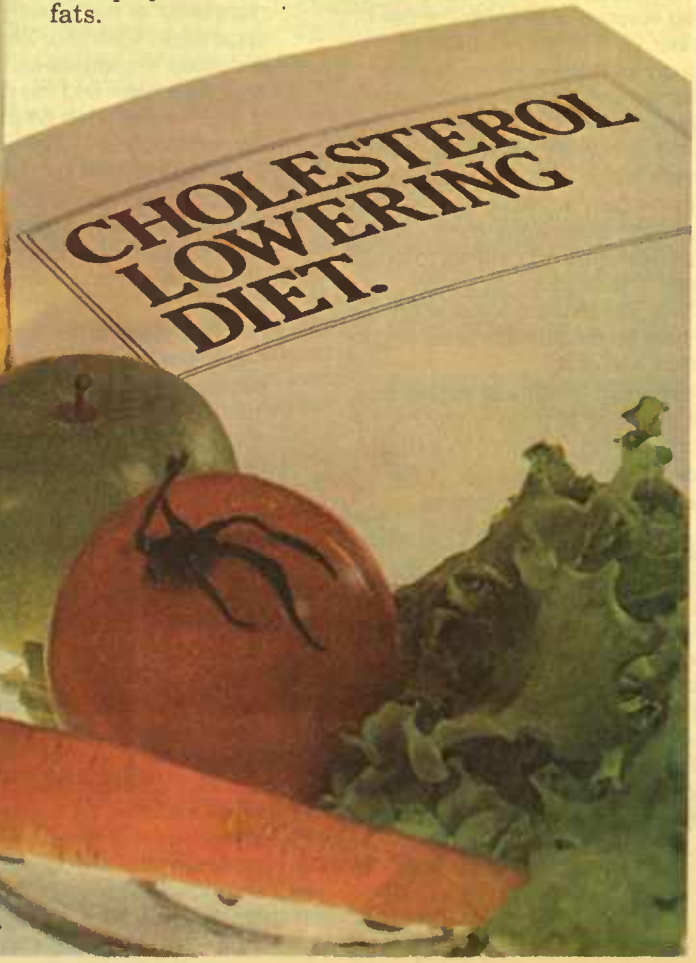
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4 Fader, Jean, I paint what I feel. *Canad. Nurse.* 68:7:31-33, Jul. 1972.

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The puzzle on page 39 is one of a series by Mary Elizabeth Bawden (R.N. B.Sc.N.) who is working at the Rheumatic Diseases Unit, University Hospital, London, Ontario as Team Leader. This was a welcomed addition to the Cardiology series... Hope you enjoyed working out the hidden answer.

Clinical Wordsearch

Answers

Puzzle # 2

1 Digoxin
2 Heart
3 Arterial
4 Rapid
5 Venule
6 Blood
7 Capillaries
8 Sinus
9 His Bundle
10 Tricuspid
11 Endocarditis
12 Myocardium
13 Mitral
14 Pulse
15 Telemetry
16 Systole
17 Brachial
18 A.V. node
19 Cardiovascular
20 Sphygmomanometer
21 Arrest
22 Fibrillation
23 Semilunar
24 Clot
25 Imitate
26 L.D.H.
27 E.C.G.
28 S.G.O.T.
29 P.T.T.
30 E.S.R.
31 Slow
32 H.S.
33 P.R.N.
34 N.P.O.
35 Q.I.D.
36 S.O.B.
37 Phono
38 Repair
39 Infarction
40 Adams

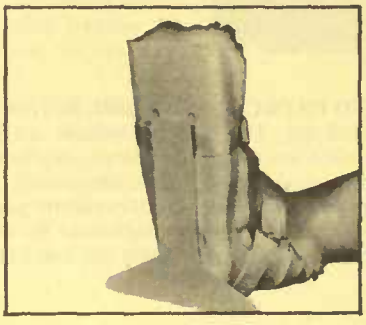
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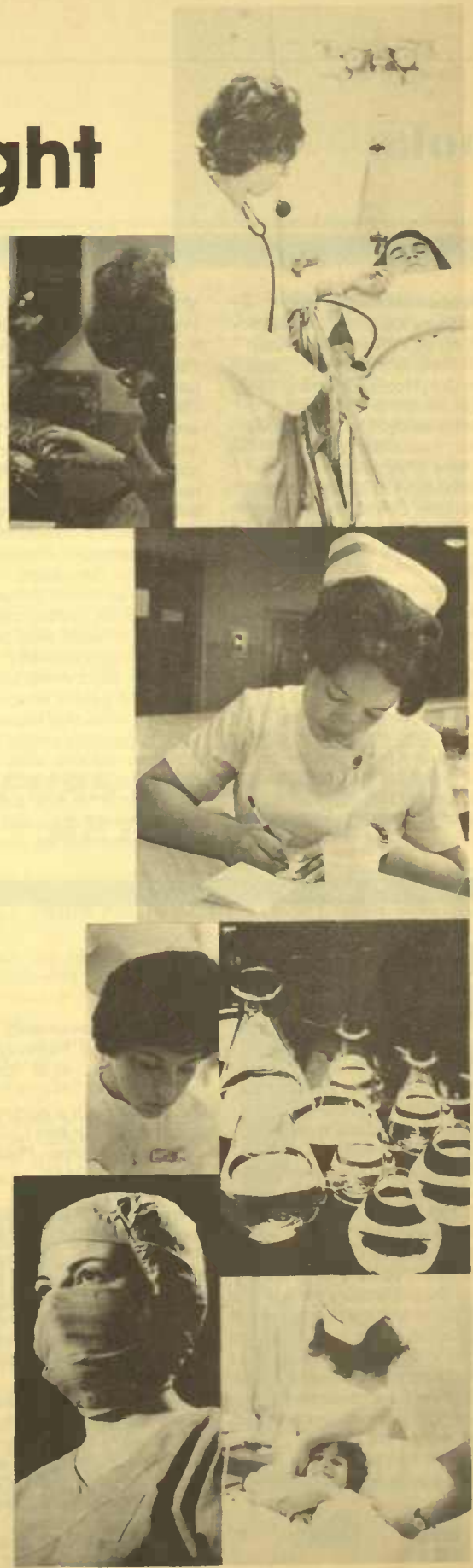
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NURSING ADMINISTRATION: Theory for Practice with a Systems Approach. *By Clara Arndt, R.N., M.S. and Loucine M. Daderian Huckaboy, R.N., B.S., M.S., Ph.D.* This practical book synthesizes theories of business management, behavioral science, and scientific method into a cohesive conceptual text for nursing administration. Using a new general systems frame of reference, discussions demonstrate theory in terms of setting objectives, budgeting, planning, organizing, directing, and controlling. 1975, 308 pp., illustrated. **Price, $13.15.**

Books

Decision Making in the Coronary Care Unit, second edition by William P. Hamilton and Mary Ann Lavin, St. Louis, The C.V. Mosby Company, 1976. *Approximate price $6.85. Reviewed by: Mrs. Candace Paris, Instructor, Niagara College of Applied Arts and Technology, School of Health Sciences, Division of Nursing, The Mack Centre of Nursing Education, St. Catharines, Ontario.*

This slim, wire-bound, paperback text is intended as a practical teaching method for effective utilization of the "nursing process" in the Coronary Care Unit.

The book consists of nine chapters dealing with specific cardiac problems, and a tenth chapter of practical exercises. Each chapter has a similar format. This includes a brief introduction to the problem, eg. "Care of the Patient With Low Blood Pressure", followed by a series of three to ten clinical situations. Each situation is described through background information, present situation, E.C.G. rhythm strip, goal and intervention. The reader is encouraged to formulate his own approach to the problem before reading the authors' suggestions. The authors have explained that although responses to problems may be varied, their suggestions should act as a catalyst for discussion.

The problems discussed in this book include cardiac pain, irregular pulse, fast pulse, slow pulse, transvenous pacemaker, low blood pressure, shortness of breath, sudden death and patient education.

The consumer population for this book is probably limited to professionals who work with cardiac monitoring equipment. It is a useful text not only for new staff orientation but for in-service education of experienced staff as well.

This text provides many cardiac problems and therapies for discussion, and promotes the scientific method of problem solving and evaluation.

Understanding the Heart and Its Diseases

Understanding the Heart and Its Diseases by John Ross Jr. and Robert O'Rourke, Scarborough, McGraw-Hill Ryerson Ltd., 1976. *Approximate Price $4.35. Reviewed by Heather Chan, B.Sc.N., Agincourt, Ontario.*

This book is easily read and understood. It explains normal heart function and the prevention and treatment of heart diseases including valvular disorders, arrythmias, coronary heart disease (arteriosclerosis), hypertension, heart failure and common congenital defects. The explanation of common tests provides useful information for lay persons. The book concludes with a look at the history of cardiac surgery to the present.

The authors' coverage of heart function meets their goal of providing a working knowledge at a basic level. More content on common cardiac drugs might be included to round out the text. In general the information seems current and accurate. Each chapter lists both general and scientific references from the 1970's.

Understanding the Heart and Its Diseases is an invaluable asset to the health education of the general public with regard to heart disease. However it could serve only as a cursory introduction for the nursing student or cardiac patient.

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Classified Advertisements

British Columbia

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gistered and Graduate Nurses required for new 41-bed acute re hospital, 200 miles north of Vancouver, 60 miles from Kamloops. nished furnished accommodation available. Apply: Director of Nurs- . Ashcroft & District General Hospital, Ashcroft, British Columbia.

gistered Nurses with psychiatric training or experience, for new ychiatric unit opening January or February 1977. Salary according RNABC contract. Please apply in writing to: The Director of Nursing, lls Memorial Hospital, 2711 Tetrault Street, Terrace, British Colum- , V8G 2W7.

eneral Duty Nurses for modern 41-bed hospital located on the aska Highway. Salary and personnel policies in accordance with ABC. Accommodation available in residence. Apply: Director of rsing, Fort Nelson General Hospital, Fort Nelson, British Columbia.

neral Duty Nurses for modern 35-bed hospital located in south- B.C.'s Boundary Area with excellent recreation facilities. Salary d personnel policies in accordance with RNABC. Comfortable rse's home. Apply: Director of Nursing, Boundary Hospital, Grand rks, British Columbia, V0H 1H0.

anted: General Duty Nurses for modern 70-bed hospital, (48 acute ds — 22 Extended Care) located on the Sunshine Coast, 2 hrs. from ncouver. Salaries and Personnel Policies in accordance with ABC Agreement. Accommodation available (female nurses) in sidence. Apply: The Director of Nursing, St. Mary's Hospital, P.O. x 7777, Sechelt, British Columbia.

neral Duty Nurses required for an 87-bed acute care hospital in rthern B.C. Residence accommodations available. RNABC poli- s in effect. Apply to: Director of Nursing, Mills Memorial Hospital, 11 Tetrault St., Terrace, British Columbia, V8G 2W7.

Ontario

or RNA, 5' 7" or over and strong, without dependents, to care for 0 pound handicapped executive with stroke. Live-in, 1/2 yr. in To- nto and 1/2 yr. in Miami. Preferably a non-smoker. Wage: $190.00 to 10.00 weekly net, depending on experience plus Miami bonus. nd resume to: M.D.C., 3532 Eglinton Avenue West, Toronto, On- io, M6M 1V6.

Saskatchewan

pt. of Northern Saskatchewan Health Services requires **Public alth Nurses and Nurses** to provide primary diagnosis and treat- nt and emergency care in isolated communities. Qualifications: ccalaureate degree, or nurse practitioner course and/or two years perience preferably in a similar setting. Location: Various com- nities in Northern Saskatchewan. Beginning salaries $11,664 to 4,100 based on qualifications, and experience. Plus Northern Al- vance $47.50 to $145.00 per month depending on the community. ntact: Alice Mills, Nursing Supervisor, D.N.S. Health Services, Box 00, LaRonge, Saskatchewan, S0J 1L0. Phone: 306-425-2033. Ap- cations and resumes should be forwarded to: Public Service Com- ssion, 1820 Albert Street, Regina, Saskatchewan, S4P 2S8.

United States

R.N.s' — Immediate need exists for your services. Excellent salary, full paid benefits. We will assist you with your H-1 Visa for immigration. Various locations available. Immediate licensure available if needed. Write for an application to: Medical Staffing Services, Suite 2122, 333 North Michigan Avenue, Chicago, Illinois, 60601.

Texas wants you! If you are an **RN**, experienced or a recent graduate, come to Corpus Christi, Sparkling City by the Sea . . . a city building for a better future, where your opportunities for recreation and studies are limitless. Memorial Medical Center, 500-bed, general, teaching hospital encourages career advancement and provides inservice orientation. Salary from $802.53 to $1,069.46 per month, commensurate with education and experience. Differential for evening shifts, available. Benefits include holidays, sick leave, vacations, paid hospitalization, health, life insurance, pension program. Become a vital part of a modern, up-to-date hospital, write or call: John W. Gover, Jr., Director of Personnel, Memorial Medical Center, P.O. Box 5280, Corpus Christi, Texas, 78405.

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Alfred Hospital

Commercial Road, Prahran, 3181

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Applications are invited from qualified nursing staff to fill positions in general ward areas, operating theatres and intensive care areas. At present Alfred hospital has 523 acute care beds which will increase to 730 beds when a new ward block opens in the near future. This expansion requires an increase in nursing establishment to meet the extra service needs. Three post basic courses are conducted:

1. Renal Intensive Care
2. Cardio thoracic care
3. Acute respiratory care

Alfred Hospital is a school of nursing admitting 240 students annually. It is also affiliated with the Monash University School of Medicine being responsible for teaching and research activities.

SALARIES: Sisters — 1st year graduate from SA7987.20 (Canada $6684) with increments annually to SA9380.80 (Canada $7850). Penalty rates are paid. Uniforms are provided and laundered. Accommodation is available close to the Hospital which is within 15 minutes of the City centre. For prospective migrants the Hospital is willing to act as sponsor if the applicant is appointed.

Applications together with a recent photograph and the names and addresses of two referees and/or requests for further information to be directed to Miss N. Sewell, Director of Nursing, ALFRED HOSPITAL, Commercial Rd, Prahran, Victoria, 3181, Australia. 4214

THE REGISTERED NURSES' ASSOCIATION OF ONTARIO

invites applications and nominations for the position of

EXECUTIVE DIRECTOR

RNAO enters its second fifty years of service with a new focus geared to optimizing the effectiveness of the nurse in contributing to the quality of life. The position of Executive Director of the Association has tremendous scope for challenge, creativity and innovation and affords opportunity for an exciting and enriching experience.

The Executive Director, as the executive officer of the Association, has overall responsibility for carrying out policies, established by the Board of Directors, pertaining to the management and administration of the affairs of the Association.

The applicant should have university preparation at the Master's level, a broad nursing background and administrative experience.

Written applications or nominations, accompanied by a resumé of qualifications and names of referees, will be received *in confidence* by:

The Chairman
Search Committee
Box 31, Islington, Station B
Etobicoke, Ontario M9C 4X9

Dr. Everett Chalmers Hospital
Hôpital Dr. Everett Chalmers
Rue Priestman St.
P.O. Box/C.P. 9000
Fredericton, N.B. E3B 5N5
Tel. 506-454-0710

Patient Care Co-Ordinator — Psychiatry

Co-Ordinator required to direct the Nursing programme for a Psychiatric Unit of a modern 485 bed hospital, opening in September 1976.

The Psychiatric programme will service an In-patient Unit of 33 beds, as well as an Out-patient-Day Care facility.

This offers a unique opportunity for a self directed individual to assist in the organization of a new clinical service.

Qualification

Graduate Nurse, eligible for New Brunswick Registration.
Broad clinical background in Psychiatric nursing, some experience at the senior level.
Baccalaureate degree in nursing desirable.

Salary

Commensurate with experience and qualifications.

Send resume to:

Director of Staff Relations
Dr. Everett Chalmers Hospital
P.O. Box 9000
Fredericton, New Brunswick
E3B 5N5

Director of Nursing Opportunity at

The Clarke Institute of Psychiatry, Toronto

The Institute is internationally known and highly regarded for research, education and service in mental health. Its 153 in-patient beds tell only part of the treatment story which includes investigation into causes of mental illness while integrating research into in-patient and out-patient clinical programs.

The Director of Nursing should be an administrator, teacher, researcher, consultant, coordinator who enjoys influencing and shaping care in a multi-disciplinary environment. Requirements include a Masters level from recognized course instruction or above and registration in Ontario. Salary and fringe benefits are in line with the key nature of the responsibilities.

The Institute is university affiliated and cross-appointments may be arranged.

Applications will be received by the Executive Director until October 15, 1976.

Clarke Institute of Psychiatry
250 College Street
Toronto, Ontario
M5T 1R8

The Nursing Department of the Rehabilitation Institute of Montreal will present a four week intensive course on rehabilitation care, from October 18th to November 12th 1976.

This course is opened to experienced registered English speaking nurses who are specially interested in education and in the care of convalescent, handicapped and long term patients.

For further information and details of the course, apply immediately to:

The Director of Nursing
Rehabilitation Institute of Montreal
6300 Darlington Avenue
Montreal, Quebec
H3S 2J4
Tel.: (514) 735-3741, ext. 262

The Montreal Children's Hospital

Registered Nurses Nursing Assistants

Our patient population consists of the baby of less than an hour old to the adolescent who has just turned seventeen. We see them in Intensive Care, in one of the Medical or Surgical General Wards, or in some of the Pediatric Specialty areas.

They abound in our clinics and their numbers increase daily in our Emergency.

If you do not like working with children and with their families, you would not like it here.

If you do like children and their families, we would like you on our staff.

Interested qualified applicants should apply to the:

Director of Nursing
Montreal Children's Hospital
2300 Tupper Street
Montreal, Quebec, H3H 1P3.

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The Canadian Nurses Association does not review the personnel policies of the hospitals and agencies advertising in the Journal. For authentic information, prospective applicants should apply to the Registered Nurses' Association of the Province in which they are interested in working.

Address correspondence to:

The Canadian Nurse
50 The Driveway
Ottawa, Ontario
K2P 1E2

Occupational Health Nurse Consultant

The Nova Scotia Department of Public Health, Occupational Health Division, Health Engineering Services invites applications for the above position for Nurses registered or eligible for registration with the Registered Nurses Association of Nova Scotia.

Qualifications:
The successful candidate will have an Occupational Health Nursing Certificate or its equivalent by examination and not less than ten years varied experience in occupational health nursing in industry of which five years should be at the supervisory level. Travel throughout all areas of the Province. Training in audiometry, advanced preparation in Occupational Health Nursing, and some knowledge of basic industrial hygiene would be an advantage.

Duties:
A comprehensive occupational health program is now being developed and a O.H. Nurse Consultant will be a key member of the consultant team, responsible to the Director of the Occupational Health Division for a major segment of the total program.

Salary:
Commensurate with qualifications and experience.
Full Nova Scotia Civil Service Benefits.
Competition is open to both men and women.
Please quote competition number 76-525.

Application forms may be obtained from the Civil Service Commission, J.W. Johnston Building, P.O. Box 943, Halifax, Nova Scotia, B3J 2V9, and from the Provincial Building, Sydney, Nova Scotia, B1P 5L1.

SENECA

Bursary for Post Basic Education

Registered nurses who are graduates of the York Regional School of Nursing or the Nursing Programme of Seneca College are reminded of the bursary available to assist with the expenses of post diploma nursing education.

Applicants must have two years of graduate nursing experience and a final acceptance from the institution offering the post basic programme.

Direct enquiries to:
Seneca College, Leslie Campus
1255 Sheppard Ave. East
Willowdale, Ont. M2K 1E2
Student Services
York Regional Scholarship

SENECA COLLEGE
OF APPLIED ARTS AND TECHNOLOGY
1255 SHEPPARD AVENUE EAST WILLOWDALE ONTARIO M2K 1E2

Rehabilitation for the Ostomy Patient

The Continuing Education Programme of the Faculty of Nursing, University of Toronto in co-operation with the Canadian Cancer Society will offer a two day seminar on the Rehabilitation of the Ostomy Patient.

Purpose of the Programme

1. To assist nurses to develop a practical philosophy concerning the rehabilitation of the ostomy patient.
2. To assist nurses to update their basic knowledge concerning the physiological and the psychological components of the care of the ostomy patient.
3. To make available, to nurses current literature and current resource personnel.

Course Co-ordinators

Mrs. M. Barter, R.N.
Research Associate
Continuing Education Programme
Faculty of Nursing
University of Toronto

Miss Enid Wilson, R.N., E.T.
Clinical Coordinator
Sunnybrook Medical Centre
Toronto, Ontario

Student Population
Registered nurses and allied health professionals.
Registration will be limited to 100. Early registration is suggested.

Date: December 9 and 10, 1976
Fee: $30.00 for two days. Lunch and coffee will be provided.
Place: The Debates Room
Hart House, University of Toronto.

For further information please contact:
Mrs. Dorothy Brooks, Chairman
Continuing Education Programme
Faculty of Nursing
University of Toronto
50 St. George Street
Toronto, Ontario M5S 1A1
Telephone: 978-8559

Assistant Director of Nursing

With preparation and/or experience in Rehabilitation Nursing and activity programming for Chronic patients.

Will be required to work closely with Rehabilitation Staff of adjacent Centre in assessing and determining patient programmes.

Qualifications
B.Sc. in Nursing or equivalent preferred plus 2 - 5 years experience in Rehabilitation Nursing.

Salary
Salary commensurate with qualifications and experience

Apply to:
Administrator
The Shaver Hospital for Chest Diseases
541 Glenridge Avenue
P.O. Box 158
St. Catharines, Ontario
L2R 6S5



Nursing Education at Royal Prince Alfred Hospital

Sydney, NSW, Australia

Royal Prince Alfred Hospital is Australia's largest teaching hospital (1532 beds) and the most highly specialised acute hospital in the country. It is also a teaching hospital of Sydney University, which it adjoins.

Graduate nurses at RPA get wide clinical experience in the most modern and advanced medical environment available in Australia. They also undergo continuous in-service education to ensure that their theoretical knowledge keeps pace with their clinical experience.

Post-Graduate Education: RPA offers trained nurses a choice of seven post-graduate courses in nursing: obstetrics, gynaecology, neo-natal intensive care, intensive care, neurology and neurosurgery, cardio-thoracic, and operating theatres. Since the courses are heavily booked, early application is invited.

Basic Nursing Education: Each year some 400 young men and women come to RPA to train as nurses on the 3-year course which prepares them for the final examination of the Nurses' Registration Board of New South Wales; this qualification is recognised throughout Australia and in many hospitals overseas.

If you would like to join Royal Prince Alfred Hospital either as a graduate member of the staff or as an entrant for either the basic training or post-graduate courses, please write to or telephone:

Ms Margaret Nelson
Director of Nursing
Royal Prince Alfred Hospital
Camperdown, NSW 2050
Tel: Sydney 51-0444.
Australia.

Two Head Nurses

Two Head Nurses with preparation and/or demonstrated competence in **Psychiatric Nursing** and **Management** functions.

One to be responsible for participation in the organization, initiation, and the management of a **New Psychiatric In-Patient Unit.** The other to be responsible for participation, organization and management of an existing **Psychiatric Day Care Unit.**

Forward complete resume to:

Director of Personnel
Stratford General Hospital
Stratford, Ontario
N5A 2Y6

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For further information write enclosing complete resume to:
Civil Service Commission
904 - 155 Carlton Street
WINNIPEG, Manitoba R3C 3H8

City of Winnipeg Health Department requires Director of Nursing

The successful applicant will be responsible for the integration of the Nursing Division program within the Civic Service and other community agencies. Will exercise considerable judgement and carry out programs of evaluation, planning, research, education, and counselling with respect to Public Health Nursing.

Applicants must possess a Bachelor's degree in nursing. At least five years' experience in the public health nursing field, some of which must have been at a supervisory, administrative or teaching level.

Salary: $19,916.00 to $24,063.00 per annum — 1975 Rates.

Apply in writing to:
Mr. J.W. Woodward
Manager of Employment
Personnel Department
Main Floor - 510 Main St.,
Winnipeg, Manitoba
R3B 1B9

Director of Nursing

Director of Nursing required for a 32-bed active treatment hospital situated in Southern Alberta. Experience and post graduate training helpful but not required.

Apply, forwarding complete resume, to:

Administrator
Macleod Municipal Hospital
Fort Macleod, Alberta
T0L 0Z0

Nursing Education & Research

Position: Coordinator

Department: Nursing Education & Research

Responsible to: Director

Qualifications: graduate from a recognized School of Nursing, Operating Room experience, bilingual (French & English) teaching experience, degree in Nursing Science or equivalent.

Apply to:
J.F. Roger Brunet
Recruiting Officer
Ottawa General Hospital
58 Bruyere St. Ottawa, Ont.
K1N 5C8

Foothills Hospital, Calgary, Alberta

Advanced Neurological-Neurosurgical Nursing for Graduate Nurses

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Beginning: March, September

Limited to 8 participants
Applications now being accepted

For further information, please write to:
Co-ordinator of In-service Education
Foothills Hospital
1403 29 St. N.W. Calgary, Alberta
T2N 2T9

Life should be more than a job

especially when your job is life.

You already know that. And that's probably one of the reasons you chose to be a nurse.

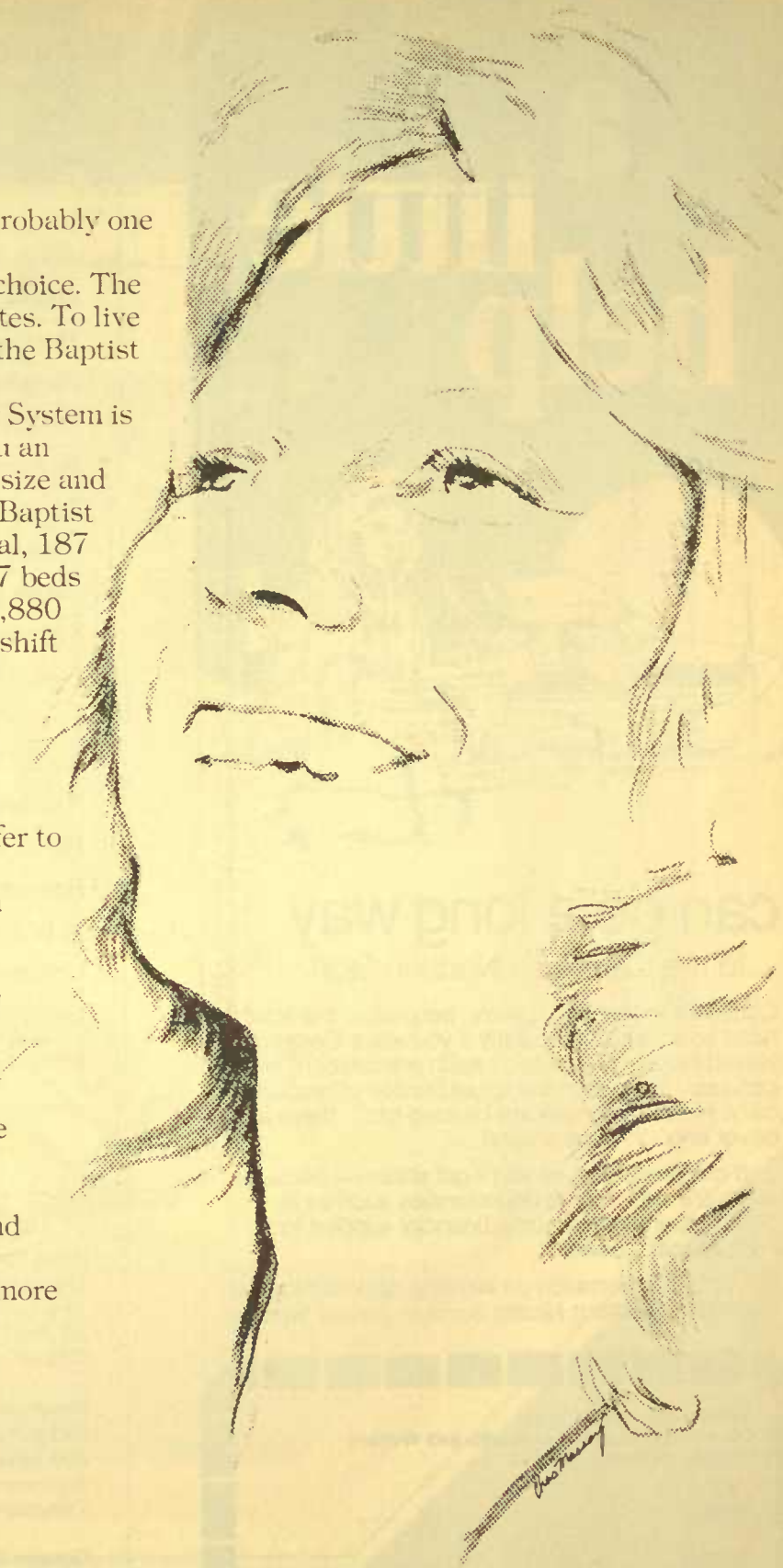
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Air fare to Little Rock with a one year commitment, temporary housing facilities, all visa arrangements, and liberal benefits are all a part of our offer to you. The Arkansas State Board of Nursing will recognize your Canadian education and license without any examinations here.

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Especially when your job is Life.

Write or call:
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Baptist Medical Center System
9600 West 12th, Little Rock, Arkansas 72201
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For further information on Nursing opportunities in Canada's Northern Health Service, please write to:

Medical Services Branch
Department of National Health and Welfare
Ottawa, Ontario K1A 0L3

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Address .....

.....

City ..... Prov. .....

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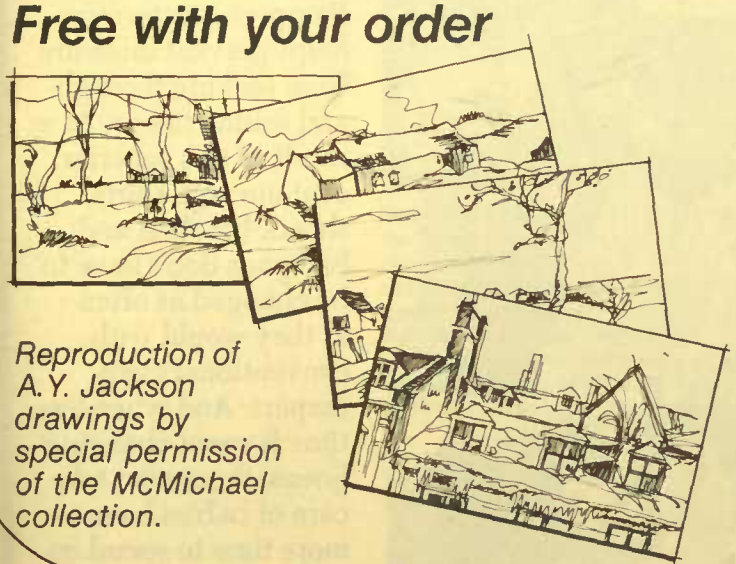
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The Canadian Nurse

The official journal of the Canadian Nurses' Association published monthly in French and English editions.

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This month's cover photo, highlighting the theme of the second in the three-part series on the cardiovascular system in health and disease, was obtained from Sunnybrook Medical Centre, Coronary Care Unit which also supplied the photo on page 38. Photos by Pearce Audio Visual Presentation.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses' Association.

ISSN 0008-4581

Indexed in International Nursing Index, Cumulative Index to Nursing Literature, Abstracts of Hospital Management Studies, Hospital Literature Index, Hospital Abstracts, Index Medicus. *The Canadian Nurse* is available in microform from Xerox University Microfilms, Ann Arbor, Michigan, 48106.

The Canadian Nurse welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-space. Send original and carbon. All articles must be submitted for the exclusive use of *The Canadian Nurse*. A biographical statement and return address should accompany all manuscripts.

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Perspective

Will the real nurse please stand up? It is just a year now since I directed a special appeal to all of the nurses who care about what's happening to their profession to share their experiences with their fellow nurses. The fact that you do care became evident almost immediately as the number of really good submissions rose by leaps and bounds.

As editors, we complain loudly because the pile of unpublished manuscripts grows higher each day. At heart though, we cannot help but be pleased.

Our problem is more fundamental than an embarrassment of riches.

What we have to ask ourselves now is: "Is this really what nursing is all about?" Sure, we believe in continuing education and better teaching programs and more research and psychological support and understanding for patients but what's happened to good "old-fashioned" nursing care based on sound knowledge of things like the etiology, incidence, signs and symptoms of a disease? What's wrong with talking about the diagnosis and treatment of these diseases — the drugs, equipment, and lab tests involved? What's wrong with a straightforward description of necessary nursing care, including the teaching program that is needed?

That's not to say that Canadian nurses never write this kind of clinical article. In the past few months, we've received several — many of them excellent. What worries us is the fact that articles of this type make up only the tiniest fraction of all those that cross the editor's desk.

This week we carried out a hasty and unofficial inventory of "clinical articles" carried by the journal in the past five years. We were, to put it mildly, distressed. Would you believe that we found only one clinical article on cancer? only one on gastro-intestinal disorders? only four on drugs? Where are the nurses who care for patients suffering from arthritis and rheumatism, burns, allergies and anaphylactic shock? Where are the nurses who know the signs, symptoms, diagnostic tests, treatment and nursing management involved in caring for the kidney transplant patient? the patient with hemolytic disorders? the dermatolog patient?

The Canadian Nurse is a "professional journal." As such, I believe it reflects the tendency of the profession, in the past, to direct its major efforts towards improving methods of preparation for nursing practice, attracting enough workers into the profession and encouraging administrators and teachers to study administrative and educational problems etc.

In doing so, I believe that members of the profession have shortchanged themselves. They have forgotten or overlooked the fact that, at the root of their "professionalism" is the specia body of knowledge and skills that only the members of their occupational group possess. It is this knowledge that determines the quality of their performance. And it must be developed and shared by all nurses if the profession is to advance and grow in wisdom and public stature.

— M.A.H

Herein

We have many authors to thank for their contributions to our three month series on the cardiovascular system. Among them is Penny Jessop, who



not only helped in the planning stages and theme development of the series, but also contributed one article to each of the three 'cardiovascular' issues of *The Canadian Nurse*.

Since 1974, Jessop has been Director of Public Education of the Ontario Heart Foundation, a position involving responsibility for the Foundation's education program directed toward the general public, the school population, industry and paramedical personnel in the province. She also acts as liaison through the Canadian Council of Cardiovascular Nurses, Ontario Interagency Council on Smoking and Health, and Canadian Health Educators' Society. Jessop, a graduate of St. Mary's School of Nursing, Kitchener, Ontario, and the University of Ottawa, has had a wide range of experience in a number of teaching settings. This September she participated in the IXth International Conference on Health Education held in Ottawa.

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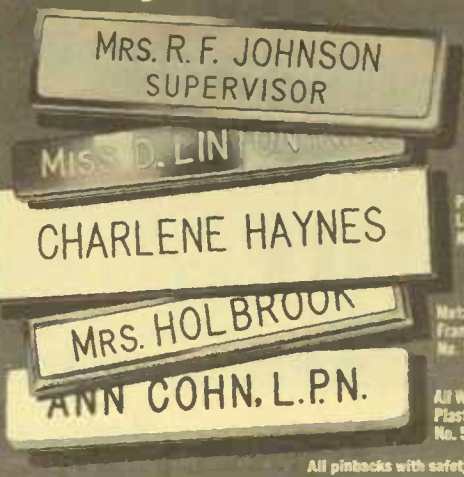
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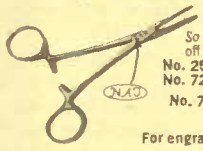


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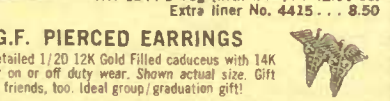
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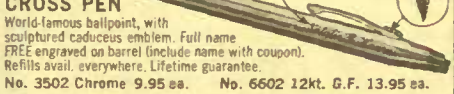
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Input

Quality of life in the North

The nurse in the North can and does play a vital role in helping people help themselves towards independence by preventing disease, prolonging life and learning healthful living.

We all know that involvement is a powerful motivation. Our community health representative program in which a native person receives training to work on his/her reserve, with the nurse, has been successful. The community health representative as well as interpreting programs offered by Medical Services, acts as liaison and is a key person on the health team. The community health representative also serves as an example to the people.

On some reserves the community health representative has been successful in forming a health committee at which meetings the nurse and the community health representative take an active part, giving information and guidance and encouraging the people to examine their health picture to realize their needs and to help find solutions.

We do not overlook the importance of education in helping to change attitudes and actions. The nurse and the community health representative work together as teachers, advisors and, most important, as good listeners. meet the people in many different settings and situations. On home visits, we see each member of the family on a "one to one" basis, from the infant to the elderly.

- We work closely with the teachers in the schools, not forgetting that these children will be the future parents and leaders.
- We have well baby clinics every month and periodically plan others i.e. diabetic etc. Whenever possible we hold workshops where we make use of various consultants from both Medical Services and other outside agencies.
- When invited, we attend band council meetings where we discuss health matters and encourage feedback from the chief and council.
- We work closely with Indian Affairs who are responsible for the education, housing, roads, water, garbage disposal and social welfare on the reserve.
- We maintain contact with the Native Alcohol Council and the Provincial Alcohol Commission.
- In our work we also meet with the school committee, with native women's groups, with native leaders (including the subtle), with people outside the reserve such as doctors, R.C.M.P., Provincial Public Health and Welfare and the clergy.

In spite of disappointments and drawbacks, there are many compensations and and many successes involved in working in the North. Some of these are: more people taking advantage of early prenatal care, earlier seeking of medical help and hospital care, improved attendance at child health clinics, regular checkups for the chronically ill, more responsibility towards taking prescription medications at home including long term anti-tuberculosis chemotherapy, more seeking and using family planning, more taking advantage of good dental and eye care.

In most instances it is encouraging that the nurse and the community health representative have been well accepted by the people. Better still, the people are becoming more interested in their own health picture and are demanding better standards.

We can learn much and derive satisfaction and pride from our native history and culture which is most essential in our pursuit of self esteem and self actualization but there is no going back to "the good old days," we must look ahead! Basically, Indian people are a happy people and the fortunate nurse, no matter her color or creed, who has a sense of humor and who strives to attain the qualities of empathy, compassion, patience and perseverance, can go a long way towards helping the native people take the initiative in finding a better quality of life.

— Irene Desjarlais, PHN, Nurse in Charge, Medical Services Health Centre, Fort Qu'Appelle, Sask.

The above is excerpted from a report prepared by the author for delivery at the last CNA annual meeting. Due to the air strike, she was unable to address the delegates in person and has asked the Journal to share her thoughts with readers.

A safety lesson

Statistics show that many children under the age of four are killed or injured annually in automobile accidents. This number could be reduced if proper restraints were used while traveling. Children riding in the cargo area of trucks or station wagons, sitting on mother's knee or unrestrained in a vehicle are common practices that endanger a child's life on the highway.

Why, with all the evidence supporting the benefits of child restraints, do we still see young children jumping about in cars as they travel down the highways? Who is responsible for their safety? Most people would agree that parents are responsible for their children's safety and the majority of parents take this responsibility seriously. Why then are so many children traveling unsafely? Perhaps it is because parents do not realize the dangers of a child playing in the rear of their station wagon. It may be that in our fast-paced society parents haven't the time to secure their child before taking off.

Safety restraints should be regarded as "preventive medicine" in the same context as immunization and to a child no doubt less painful. Children should be taught by their parents that safety belts are a part of traveling as blankets are a part of sleeping. Teachers, beginning in nursery school, should reinforce what a child already knows about auto safety and fill in the gaps left by parents.

Since motor vehicle accidents pose the greatest single threat to a child's life following the neonatal period, this is surely one area of health prevention that needs to be stressed. It has too long been neglected in our child care books and by government agencies, safety organizations, health workers, schools and parents.

— Geraldine Brooks Walsh, Framingham Union Hospital Nursing School, Framingham, Mass.

A change for the better

Recently, I received the August and September editions. I see that your format is changing. Good! I, for one, like it. I found several articles interesting, well worth reading ...

— Gerardina van Baal Philp, Senneville, P.Q.

A stand against cutbacks

I have never felt any need to write *"The Canadian Nurse"* for I fel that the people that edited the magazine were very competent, but since reading the June and July issue I thought I would like to write my tw bits worth.

The magazine is improving all the time. The varied updated nursing topics are certainly worth sharing with all nurses.

I agree with Maxine Enderton *(Input, July 1976)* that it is about time we lethargic, apathetic nurses took a stand. But if we do, what then? Many of us would have our front teeth knocked in for speaking up against the "cutbacks in budget."

I feel that anti-inflation measures like these are only hitting at the defenceless sick and handicapped public. Shutting down wards, cutting down staff, replacing competent staf with lay help is certainly not the answer. All it does is make for a disgruntled staff and patients. Yes, let us take a stand and protest but remember we are only a small group compared to the millions in Canada. Have we got enough of the renegade in us to stand up to this tyrannical government? You know what usually happens to renegades; they are shot down.

—Hope Nowlin, R.N., Calgary Nurses Private Duty Registry, Calgary, Alta.

The universal language

Like so many other nurses' husbands I read *The Canadian Nurse* and find it a rather good publication. I like your new layout.

...For the last few months there has been labor unrest in the nursing field here in Quebec.

It has been stated by doctors that some young children have died due to this labor trouble. ...Now we read that there is a pool of nurses that could help out and save lives but since they do not speak French they cannot work. I ask — does a three-year-old child care what language a nurse speaks? For that matter do you think parents care if the nurse speaks French?

— Lorne Ulley, Verdun, Quebec.

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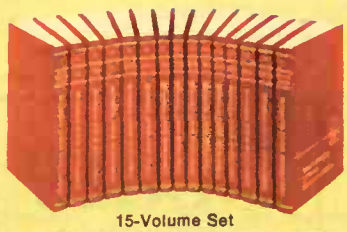


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used pre-surgically to reduce the bulk of tumor and make surgical removal feasible. In cases of inoperable breast cancer, it can be the treatment of choice and in this instance has a cure rate of some 30 percent. Palliative radiotherapy is used to control spread and particularly to treat metastatic bony deposits for associated pain.

The basic premise for many years has been that most breast cancers arise in a single focus, spread at an indeterminate time to the regional station of lymph nodes and then later enter the blood stream. Logically then, the primary therapeutic attack has consisted of mastectomy with surgical removal and/or irradiation of the primary lymphatic drainage.

This basic premise is now being challenged on two points:

1) Primary cancer of the breast may exist in multiple foci in almost half of the patients.

2) Lymphatic and lymph node permeation does not necessarily precede blood-borne dissemination of breast cancer.

For these reasons, the patient with breast cancer and nurses must not feel that because the patient is receiving radiotherapy, she has a hopeless future or that radiotherapy only has a palliative role. Indeed, in most cancer centers the treatment of breast cancer is a multidisciplinary approach in which surgical removal, radiotherapy, chemotherapy and

of youth but you have gained perspective. Maturity is a stage of life with special significance. It is a time for you to put into effect the wisdom that is unattainable at any preceding age. Some doors are closed by illness and the loss of friends, but new doors have been opened by your maturity.

Not everyone will turn in retirement to the same source for satisfaction.

Having something to do, not necessarily as a means to supplement your livelihood, will add purpose to your life but you show poor judgement if you seize upon the first post-retirement position that offers itself.

Retirement is not meant to be a dead stop, but a change of direction. You will be happy to get up every morning if you will have something to do. Much of the unhappiness of retirement is caused by people who really want to be up and doing, but have no idea what they ought to be doing.

All during your working years you followed a narrow path. You will find that what you get out of retirement depends on the investment you make in it ahead of the deadline — friends, hobbies, and so on. One precept will apply to whatever you choose, keep it simple, have fun and don't make it a burden that is pointless or irksome. While you were working you were doing something everybody else around you had an interest in. *Now* is your chance to develop different

ve nursing

The nursing profession must relentlessly search for new avenues for its members to demonstrate their knowledge and skill while professionally and gainfully employed. In fact, it should use some of the more ethical techniques employed by big business and corporations to find new markets for their products. It must look beyond hospital walls, public health nursing practice, and classrooms of schools of nursing, colleges, and universities.

Massive unemployment is looking nursing in the face and, instead of looking for scapegoats, the time would be better spent looking for new and meaningful roles for unemployed and future nurses. It does not suffice to blame government cutbacks or to evaluate the two-year nursing program, or even to mention wage levels.

One area that maybe has not been fully tapped is preventive care. How does Social Preventive Nursing (SPN) sound? We have had Social Preventive Medicine for decades, why not SPN?

We have the expertise in Canada and the nursing profession to make it work. SPN could be everything that relates to the understanding and improvement of the delicate balance between man and his environment. It could involve not only agents of ill-health and disability, but also individual and social patterns of behavior that make man more susceptible to those agents. It could be concerned with the effectiveness and efficiency of the system of nursing care and particularly with improving the outcomes of the care.

SPN could be defined as dealing with problems of public health and their solutions. This includes studies of the distribution and behavior of disease in human populations; definition of the agents responsible for the patterns observed; consideration of the modifying effect of social and environment conditions on disease evolution; and the assessment of the health and efficiency of people exposed to various external circumstances. Linked with these subjects is the design of measures intended to control or prevent disease and the field assessment of their value in public health practice. SPN would also encompass the objective study of the organization and functioning of nursing services with particular emphasis on the measurement of their efficiency.

Readers should thoroughly assess this proposal. Maybe one day we will have nurses practising SPN in public libraries and, instead of bandaging cut fingers in school yards, nurses will be teaching in classrooms. Who knows?

— Mohamed H. Rajabally, R.N., Ed. M., Kelowna, B.C.

We stand corrected

As the author of "Understanding the Patient in Emergency," July 1976, I would like to point out that the wording of one sentence in this article did not appear in print as it was originally submitted. The sentence I refer to concerns the importance of psychological support for the emergency patient in pain and should read as follows: "If the doctor orders an analgesic for the emergency patient, the administration of it is most important. But, very frequently in an emergency situation, analgesics are contraindicated, as with head-injured patients or until definitive diagnosis is made, because they may mask the patient's symptoms. Consequently, emotional support of this patient is important to reduce the level of fear and anxiety and in turn perhaps reduce the level of associated pain.

— Wendy McKnight, R.N., Ottawa, Ont.

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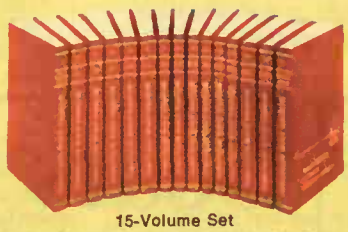


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Input

Radiotherapy has many uses

Ada Butler's article, "Breast Cancer," *(June, 1976)* was one of the better articles to appear in nursing journals and has good teaching value. However, I would like to suggest that her statement "radiation may be used to manage palliation of symptoms to improve the quality of the person's life," while valid, may lead to serious misconceptions, as this is not the *only* role for which radiation therapy is used.

Radiation therapy in breast cancer was used in Edinburgh in the late 1940's with reduced surgical procedures and adopted in many cancer centers throughout the world. It is used in conjunction with surgery to cover areas beyond that which the surgeon can operate and has been shown to improve the cure rate. It is used pre-surgically to reduce the bulk of tumor and make surgical removal feasible. In cases of inoperable breast cancer, it can be the treatment of choice and in this instance has a cure rate of some 30 percent. Palliative radiotherapy is used to control spread and particularly to treat metastatic bony deposits for associated pain.

The basic premise for many years has been that most breast cancers arise in a single focus, spread at an indeterminate time to the regional station of lymph nodes and then later enter the blood stream. Logically then, the primary therapeutic attack has consisted of mastectomy with surgical removal and/or irradiation of the primary lymphatic drainage.

This basic premise is now being challenged on two points:

1) Primary cancer of the breast may exist in multiple foci in almost half of the patients.

2) Lymphatic and lymph node permeation does not necessarily precede blood-borne dissemination of breast cancer.

For these reasons, the patient with breast cancer and nurses must not feel that because the patient is receiving radiotherapy, she has a hopeless future or that radiotherapy only has a palliative role. Indeed, in most cancer centers the treatment of breast cancer is a multidisciplinary approach in which surgical removal, radiotherapy, chemotherapy and hormone manipulation are all considered and used as appropriate to improve, not only the cure rate, but the quality of life.

— M.M. Freeze, R.N., B.S.N., Hospital Unit Supervisor, Cancer Control Agency of B.C., Vancouver, B.C.

Thoughts on retirement

Don't look on retirement as though you had been deprived of something, but in the spirit of having something fresh added to your life. You are not starting out empty-handed, but from the point at which you have assimilated the lessons of half a century. Those years should be a crown, not a burden.

By retirement time you have lost some of the plagues and insecurities of youth but you have gained perspective. Maturity is a stage of life with special significance. It is a time for you to put into effect the wisdom that is unattainable at any preceding age. Some doors are closed by illness and the loss of friends, but new doors have been opened by your maturity.

Not everyone will turn in retirement to the same source for satisfaction.

Having something to do, not necessarily as a means to supplement your livelihood, will add purpose to your life but you show poor judgement if you seize upon the first post-retirement position that offers itself.

Retirement is not meant to be a dead stop, but a change of direction. You will be happy to get up every morning if you will have something to do. Much of the unhappiness of retirement is caused by people who really want to be up and doing, but have no idea what they ought to be doing.

All during your working years you followed a narrow path. You will find that what you get out of retirement depends on the investment you make in it ahead of the deadline — friends, hobbies, and so on. One precept will apply to whatever you choose, keep it simple, have fun and don't make it a burden that is pointless or irksome. While you were working you were doing something everybody else around you had an interest in. *Now* is your chance to develop different ideas, and do unusual things. In other words, do what you want.

Writing has much in its favor as a hobby. It is a lonely one, but convenient, as it can be carried on anywhere without burdensome equipment. It is worthwhile because it can contribute to human knowledge and wisdom and will live long after one's life is over.

Make the most of what you have. Wherever you go, go with a whole heart, keep your eye on what is new. Do not let the moments rust away and remember — beauty in youth is an accident of birth, in maturity, it is a creation.

— Dorothy Dent, RN, Ottawa, Ontario.

Social preventive nursing

The nursing profession must relentlessly search for new avenues for its members to demonstrate their knowledge and skill while professionally and gainfully employed. In fact, it should use some of the more ethical techniques employed by big business and corporations to find new markets for their products. It must look beyond hospital walls, public health nursing practice, and classrooms of schools of nursing, colleges, and universities.

Massive unemployment is looking nursing in the face and, instead of looking for scapegoats, the time would be better spent looking for new and meaningful roles for unemployed and future nurses. It does not suffice to blame government cutbacks or to evaluate the two-year nursing program, or even to mention wage levels.

One area that maybe has not been fully tapped is preventive care. How does Social Preventive Nursing (SPN) sound? We have had Social Preventive Medicine for decades, why not SPN?

We have the expertise in Canada and the nursing profession to make it work. SPN could be everything that relates to the understanding and improvement of the delicate balance between man and his environment. It could involve not only agents of ill-health and disability, but also individual and social patterns of behavior that make man more susceptible to those agents. It could be concerned with the effectiveness and efficiency of the system of nursing care and particularly with improving the outcomes of the care.

SPN could be defined as dealing with problems of public health and their solutions. This includes studies of the distribution and behavior of disease in human populations; definition of the agents responsible for the patterns observed; consideration of the modifying effect of social and environment conditions on disease evolution; and the assessment of the health and efficiency of people exposed to various external circumstances. Linked with these subjects is the design of measures intended to control or prevent disease and the field assessment of their value in public health practice. SPN would also encompass the objective study of the organization and functioning of nursing services with particular emphasis on the measurement of their efficiency.

Readers should thoroughly assess this proposal. Maybe one day we will have nurses practising SPN in public libraries and, instead of bandaging cut fingers in school yards, nurses will be teaching in classrooms. Who knows?

— Mohamed H. Rajabally, R.N., Ed. M., Kelowna, B.C.

We stand corrected

As the author of "Understanding the Patient in Emergency," July 1976, I would like to point out that the wording of one sentence in this article did not appear in print as it was originally submitted. The sentence I refer to concerns the importance of psychological support for the emergency patient in pain and should read as follows: "If the doctor orders an analgesic for the emergency patient, the administration of it is most important. But, very frequently in an emergency situation, analgesics are contraindicated, as with head-injured patients or until definitive diagnosis is made, because they may mask the patient's symptoms. Consequently, emotional support of this patient is important to reduce the level of fear and anxiety and in turn perhaps reduce the level of associated pain.

— Wendy McKnight, R.N., Ottawa, Ont.

News



Nurses from 70 nations around the world were among more than 1,000 delegates to the Ninth International Conference on Health Education in Ottawa. The theme of the conference, which took place from August 29 to September 3, was "Health Education and Health Policy in the Dynamics of Development." Approximately 100 nurses were among the representatives of health professions and voluntary associations, as well as government agencies, who attended.

Above, nurses from several Canadian provinces are pictured during the conference with their international counter parts. Countries represented in the group include in addition to Canada, the United, States, the United Kingdom, Australia and South Africa.

Two key issues that emerged from the six-day meeting were the need to make more effective use of preventive measures in health care and the need to tailor health education to the specific environment and culture of the people receiving these services. Conference participants agreed that it is imperative that health education be demystified and that ways be found of helping the consumer and provider of health care to work together. The terms used when dealing with the consumer of care should be simple and concrete. Self-help should be encouraged with the assistance of paramedical workers comparable to the barefoot doctors of China. With minimal training, these people could act as catalysts to lay people and help demystify medicine. Participants also agreed on the need for government support of health education.

ICN Proposes Primary Care Conference

The International Council of Nurses has proposed to the World Health Organization that a joint conference or seminar on the subject of nurses vis-a-vis the provision of primary health care be held next year.

ICN President Dorothy Cornelius initiated discussion of such a conference at a meeting with Dr. Halfdan Mahler, Director-General, WHO, in March. "Since the aim of both ICN and WHO is to improve health care for all people," she said, "ICN's purpose in initiating this meeting with WHO was to explore how to accomplish mutual goals."

On July 20, ICN and WHO staff in Geneva met for preliminary discussion of the setting up of a joint working party to plan the organization and conduct of the conference, projected for 1977.

Commenting on the purpose of the proposed conference, ICN Executive Director Adele Herwitz said, "One of the major objectives of ICN is the full and effective participation of nurses in the provision of both qualitative and quantitative health care to the people of the world. In this present age of new and growing knowledge in health care, a joint WHO/ICN international seminar or conference on this subject would be supportive to the nurses' effective functioning within the health care delivery team."

One of the goals shared by ICN's 84 member associations, grouping close to a million nurses around the world, is to ensure maximum utilization of nurses' services in the provision of health services within each country.

Grant teaches nurses to aid retarded

A $68,000 grant from the Atkinson Charitable Foundation will help produce a film series to teach graduate and student nurses about current approaches to mental retardation. A series of five half-hour films containing a course of eight lectures will be made for The Hospital for Sick Children, Toronto. The course is designed to give general duty nurses a more complete understanding of the special problems of the mentally retarded.

Names and faces

Nurses at ILO Conference contribute to world code

Official preparation of an international instrument on the conditions of work and life of nursing personnel got under way during the 1976 International Labour Conference in Geneva, last June. A total of 48 nurses from 34 countries attended the conference as delegates or advisers to government, worker or employer groups, or as observers.

"The nurses made outstanding contributions to the discussions of the Committee on Nursing Personnel and had a tremendous impact on the meeting," said ICN Executive Director Adele Herwitz in reporting on the meeting to the presidents of ICN's 84 member associations.

"Nurses expressed their opinions very clearly and were able to bring other delegates to a clearer understanding of the special problems facing the nursing profession. This conference was a perfect illustration of the need for nurses to attend such meetings in order to speak authoritatively for their profession and to defend their rights."

The proposed conclusions adopted in June will be sent by ILO to governments for their comments. A report will then go to the 1977 International Labour Conference, which will hold a second and final discussion on the subject.

The preliminary conclusions drawn by this year's conference include the statement that nurses should be able to refuse to perform specific duties where performance would conflict with their religious, moral or ethical convictions, provided they inform their supervisor in good time and are satisfied that nursing care is ensured. If this clause is adopted by next year's conference, says ILO, it will be the first time that such a conscience clause has been featured in an ILO standard.

Other significant recommendations include two relating to career development and remuneration. It was agreed that measures should be taken to give nursing personnel reasonable career prospects by providing for a sufficiently varied and open range of possibilities of professional advancement, leadership positions in administration, education and research, and that remuneration should be commensurate with nurses' "needs, qualifications, responsibilities, duties and experience." Remuneration should take account of the constraints and hazards inherent in the profession and should be fixed at levels likely to attract persons to and retain them in the profession.

The proposed conclusions adopted this year cover the following specific subjects: policy concerning nursing services and nursing personnel; education and training; practice of the nursing profession; participation; career development; remuneration; working time and rest periods; occupational health protection; social security; special employment arrangements, nursing students and international cooperation.

ICN is asking its member associations to contact government authorities in their respective countries to voice the nursing profession's support of the proposed conclusions, with a view to ensuring adoption of an international instrument next year by ILO Member States. National associations will also seek to have nurses included in government, worker and employer delegations again next year.

NLN forecasts zero growth rate

After nearly ten years of unprecedented expansion, the number of basic nursing education programs in the United States and the number of students admitted to those programs, appear to have peaked and now are stabilized at a virtual zero growth rate.

That is the conclusion of the National League for Nursing's 1975 Annual Survey of State-Approved Schools of Nursing. The report surveys programs preparing for registered and practical nurse licensure, graduate programs leading to masters and doctoral degrees in nursing, and baccalaureate nursing programs for registered nurses only.

According to NLN Director of Research, Dr. Walter L. Johnson, the most significant question arising from the projected zero growth rate is: "Assuming the current rates of growth, to what extent will supply and demand for nursing personnel match up over the next few years?"

Despite the importance of this question, he explains, it cannot be answered at this time because a quantitative analysis of requirements for beginning practitioners according to type of preparation has not yet been done. Thus, there is no projected demand curve against which to evaluate supply trends.

The report cites another trend of major significance to the future of nursing—the tendency toward increasing part-time rather than full-time attendance in graduate programs. Because many part-time students defer dates of completion of their work, sometimes with no firm target date in mind, the report suggests this could lead to declining graduation rates despite increasing enrollments in graduate programs.

"This kind of trend should not be ignored," warns Dr. Johnson, "in the light of the prevalent notion that the shortage of nurses prepared at the graduate level is one of the most serious problems of supply today."

The current leveling off in growth, he points out, is at the end of a marked expansion that began in the late 1960's for RN education and in the early 1950's for PN education. "The rates at which numbers of programs and admissions of students were increasing," Dr. Johnson states, "could not be sustained for an indefinite period."

The declining rate of growth applicable to basic nursing education does not appear to apply as yet to RNs who were prepared in diploma or associate degree programs and who now are seeking baccalaureate degrees. The number of these graduations this year increased by 26 percent.

There was a minimal increase in the number of graduations from masters programs. However, enrolments continue to show substantial increases, with a 22 percent increase this year.

Doctoral graduations rose more than 60 percent this year from 46 to 74, but enrolments increased only slightly from 192 to 199.

Reviewing admissions, enrolments, and graduations of men and minority students, the report cites modest changes between 1972 and 1975, except for a drop in proportions of Blacks in associate degree and practical nursing programs. These decreases, however, are counter balanced by the increases in Blacks admitted, enrolled, and graduated from baccalaureate programs.

In 1975, men repesented seven percent of the RN graduates, Blacks nine percent, Hispanics six percent, and American Indians/Orientals three percent. For that same year, men represented five percent of the PN graduates, Blacks 16 percent, Hispanics 19 percent, and American Indians/Orientals five percent.

Pregnancy ... or Proteinuria?

Recent studies conducted in the Health Protection Branch laboratories, Health and Welfare Canada, have found that some pregnancy tests show a false positive result in women who have proteinuria.

Manufacturers of the commercial test kits used in the study have been asked to label their kits to indicate the exact extent of protein interference to be expected. In the meantime, health personnel are advised to take into account the possibility of protein interference in pregnancy tests.

Did you know?

Allergic contact dermatitis from poison ivy, poison oak or poison sumac is caused by a toxic substance called 3-pentadicylcatechol (commonly known as urushiol or toxicodendrol).

Symptoms include: burning, itching and reddening of the skin within 10 days after exposure. Rash and edema follow rapidly.

In mild cases, cold compresses and calamine lotion may suffice. Newer drugs for treating mild-to-moderate dermatitis are topical corticosteroids.

News

CIDA releases new health care guide

The Canadian International Development Agency (CIDA) has published the second of a series of sectoral guidelines for Canada's development assistance program for the next five years. Entitled "Social Development and Community Services," the Guidelines deal with education, population, housing, social communications and cooperatives.

In the field of health care, CIDA points out that: "It should be remembered that while Canada spends close to $400 per capita per year on health, in many developing countries the health budget is as little as two to three dollars per person, and in some of the least developed countries less than one dollar. The challenge for developing countries is how to use the limited resources at their disposal to alleviate the tremendous waste of human resources resulting from the overwhelming burden of disease, extremely high infant death rates and their exploding populations."

The guidelines suggest that top priority in the health sector be given to integrated training and curative and preventive programs in rural areas, for instance:

- training of health auxiliaries and para-medical workers;
- provision of clean water, environmental sanitation;
- health education;
- provision of simple, basic equipment for the treatment and prevention of disease;
- construction of simple buildings suited to communal uses;
- Canadian projects must be a part of national or regional health programs;
- CIDA projects must be developed within the financial scope of the recipient country;
- emphasis should be on applied research and pure research projects avoided;
- health projects in which CIDA participates bilaterally or through a non-gouvernmental organization (NGO) should rely on available or potential local resources.

Health happenings in the news

Occupational health received a strong shot in the arm recently when the Ontario government released its "Report of the Royal Commission on the Health and Safety of Workers in the Mines," prepared by James Ham of the University of Toronto.

The report contains a strong indictment of provincial and federal governments and mining corporations for failing to protect the province's 30,000 mine workers from hazardous conditions that result in death, accidents and lives ruined by disability and disease. The author of the report, Professor James Ham, points out that "the problems of the health and safety of the mine workers as discussed in the report are probably not peculiar to the mine industry." He criticized industry and government for "a serious lack of openness on matters of the health and safety of workers in the mines."

Ontario New Democratic Party leader Stephen Lewis, commenting on the Ham report said: "If the Government moves on the inspection recommendations, opens up information and makes (radiation) threshold limits law, then, boy oh boy, it will be another world in occupational health."

The Natonal Cancer Institute in the United States has come out with a new set of guidelines covering the use of X ray techniques in the detection of breast cancer. The Institute recommends that the techniques *not be used routinely* on women between the ages of 35 and 50 unless they show specific symptoms or are otherwise classified as "high risk." The guidelines are contained in a letter circulated to physicians at 27 U.S. centers participating in a national breast cancer demonstration project.

Next year could see the beginning of a **"new war on sexually transmitted disease,** expecially among young people," according to federal health spokesman, Dr. Maureen Law. The latest federal study describes the incidence of reported cases of gonorrhea as "reaching epidemic proportions" with 215.8 cases per 100,000 population.

The proposed program for detecting, treating and preventing sexually transmitted diseases hinges on agreement among federal and provincial health officials. The basis for their agreement is to be recommendations contained in a report by a committee set up in 1974 and headed by Dr. Russell Manuel of Dalhousie University.

The committee's final report was submitted to a conference of deputy health ministers last Spring but disagreement on the resolutions has prevented action on its recommendations. The contents of the report are still not available to the public.

The federal provincial advisory committee on community health, to which the report was referred, is scheduled to wrestle with the committee findings and come up with a proposal for minimum standards in the area next November.

Communicable diseases still pose a very real threat to Canadians, according to Dr. Harding le Riche, professor of epidemiology at the University of Toronto. Dr. le Riche, in a recent interview with *Toronto Star* staff writer Marilyn Dunlop, accused the federal government of being "short-sighted and stupid" in failing to set up measures to better protect Canadians against imported disease.

"About 1955, people began to believe that all communicable diseases were under control," le Riche says. "We assumed the millenium had come. Penicillin had solved all our problems. It is not at all true."

Dr. le Riche cites six diseases as an example of the gamut of infections that could threaten Canadians, including: Lassa fever, "Legionnaires' disease," Swine flu, St. Louis encephalitis, diphtheria and polio. He believes that "since 1967, the reservoir of diseases has increased in Canada" and cites the results of a recently completed study in which he found that between 20 and 30 percent of all hospital patients have infections unrelated to the reasons they are in hospital.

There is no evidence that a **Swine Flu epidemic** is even remotely likely to occur, according to Ontario's controversial government health critic author and former coroner, Dr. Morton Shulman. He points out that "practically all of the deaths in the 1918 flu outbreak were not from the virus but from secondary bacterial complications which today are routinely cured with antibiotics that were unknown in 1918."

He suggests that the reason for governments giving the go ahead to a mass vaccination program boils down to the profit some people, including drug companies, stand to make and "the favorable publicity a few politicians hope that they will get for their excellent work in the public health field."

Kidney transplants up at U of A Hospital

The weeks between July 25 and August 20,1976 were busy weeks for the University of Alberta Hospital's kidney transplant team, with a total of seven transplants being done in less than a month.

Four kidneys from two donors were transplanted in a series of operations on the weekend of August 7th and 8th.

By mid-August, 1976, 13 successful transplant operations had been done at the University hospital in Edmonton, a number which approaches the 1975 total.

A transplant team spokesman says he is hopeful that this is an indication of increasing public interest in kidney donations, an encouraging sign, as there are more than 40 patients at the University hospital who would benefit from a transplant operation. Kidneys that can't be matched at the University hospital can be taken to another center to be transplanted.

Serving as the kidney transplant center in Northern Alberta, the University hospital receives notice of available kidney donations from other hospitals. These are generally cases where the donor had previously completed a donor card, or the relative of the deceased provided authorization.

Names and Faces

CNJ talks to...

aura Barr, the nurse who has guided e collective destiny of Ontario's ursing profession for the past 16 ears, leaves the RNAO next month. e leaves with regret; she says she nows she'll miss the particular nurses nd student nurses she has worked th and that she has enjoyed her term s executive director.

But she leaves with the atisfaction of having seen organized ursing make remarkable advances in e past decade and with the firm onviction that the profession today ands on the brink of even greater ccomplishments in the immediate ture.



"I'm more excited about nursing ow than I was 16 years ago," she ays. She feels that nurses, having hared some of their traditional unctions with other health care orkers, have now assumed a unique dentity as "a helping profession" and hould capitalize on this asset. "We're here everyone else says they want o be. We have created a network of ccess to the people and now we can oncentrate on being where these eople spend most of their lives — in eir homes, at work, in schools and ndustry."

Barr feels that nurses spend too ttle time caring for each other and too uch time worrying about living up to eing "that thing called *nursing.*" She ays: "The essence of nursing is resence, because nursing doesn't go on if she's not there. This is the hing we need to protect."

She worries about the popular tendency to downgrade the two-year graduate rather than to recognize that differences in education and experience can enrich a profession. "We have created our own problems by trying to make the diploma nurse all things to all people instead of allowing them to contribute in their own way. The (professional) Association has an important role to play in offering support and recognition to all of its members and teaching them to cherish these differences."

For the RNAO, Barr sees an important decade coming up when the Association comes to grips with "The New Reality." She believes that, as a group, the profession has built up a fund of knowledge and self-esteem that will go a long way towards preparing its members to help people cope and adapt wherever they are. "Even though we never appeared to fight very aggressively for it, nurses have been the major influence on current health policy. We began to talk about prevention and promotion long before anyone else thought of it. Now we can say to people 'We'd like to meet you where you are,' and, that way, people will spend less time in institutions and more time where they want to be."

"The world is our oyster," Barr concludes, "if we can just appreciate and enjoy what we have now and set our sights on where our future lies."

CNF Scholars

Eight Canadian nurses will receive scholarships from the Canadian Nurses Foundation for the coming academic year 1976-77. The awards are used for graduate studies in the field of nursing.

Constance Jan Becker, lecturer at the University of Manitoba School of Nursing, has been awarded $3000. to study for a Master's degree in clinical nursing with a major in maternal health at the University of Texas System, School of Nursing in Austin, Texas.

Donna Jean Roe, formerly Educational Coordinator at St. Joseph's Hospital, Hamilton, Ontario, receives $3000. to study for a Master's degree in Community Nursing at the University of Toronto.

Cora Marie Price, Community Health teacher at Sault Ste. Marie College in Ontario, receives the Agnes Campbell Memorial Award which is provided by the Nursing Sisters of Canada and is administered by CNF. Price plans to study for a Master of Science in Nursing degree at Wayne State University with a major in Community Health.

Wendy Lynn McKnight, lecturer at Queen's University, Kingston, Ontario, plans to study for a Master's degree in emergency nursing at McGill University with her CNF scholarship of $3000.

Helen Bernice Garry of Vancouver, B.C. has been awarded $3000. to study for a Master's degree at the University of British Columbia. Her major field of study will focus on research into nursing practice and health care organizations and delivery.

Mary Louise McSheffrey of Oromocto, New Brunswick has been awarded a $3000. White Sister Incorporated Scholarship to finance her second year of graduate study in maternal-child health at McGill University. This is the second year McSheffrey has received a CNF scholarship.

Ann Shepherd Fenwick of Montreal has been awarded $3500. from the Helen McArthur Canadian Red Cross Fellowship for Graduate Studies. Fenwick plans to complete her Master's degree in Nursing at the University of British Columbia.

Jane Buchan of Vancouver will receive $3000. to study for a Master's degree in Community Nursing at the University of British Columbia. Buchan has recently completed a two-year contract with CUSO where she served in Malaysia as midwife and Public Health field worker.

The Canadian Nurses Foundation was established in 1962 by the Canadian Nurses Association to receive funds and administer fellowships for the preparation of nurses for leadership positions. A total of 137 nurses have been awarded scholarships under the program to date. CNF funding is voluntary and dependent on gifts, donations and bequests from individuals and organizations.

Appointments

Phyllis Craig (B.Sc.N., M.H.S.A., University of Alberta) has been appointed a full-time researcher with the Edmonton Local Board of Health. She says "Administration and research in health disciplines should be interrelated. The research program need not be large, but at least decisions are based on some statistical findings."

Craig's nursing career has included two years with Health and Welfare Canada at Norway House, Manitoba; short-term nursing assignments in Australia; and work as a public health nurse and nurse practitioner in Alberta. Her recent studies in health services administration were in part supported by the Canadian Nurses Foundation.

Susan D. Smith (R.N., Nightingale School of Nursing, Toronto; B.A. and B.Sc.N., Queen's University, Kingston, Ont.) has been appointed to the position of Nursing Practice Coordinator for the College of Nurses of Ontario. Smith is responsible for activities related to the development of standards and improvement of nursing practice for registered nurses and registered nursing assistants. She will also monitor nursing practice to identify trends in health care delivery. Smith has been head nurse at the Sunnybrook Medical Centre and nurse-teacher at the York Regional School of Nursing, Toronto.

Valerie Hooper (R.N. Grace Hospital School of Nursing, Winnipeg, Man.; B.Sc.N., U.B.C.) has been appointed assistant registrar of the 18,000 member RNABC.

Hooper will be involved in assessing candidates for nurse registration in B.C. and in interpreting registration policies of the association.

She has previously held positions as nursing instructor in two Ontario schools of nursing and has practiced nursing in B.C. and Quebec. She also served as the official head of a nursing delegation sponsored by the RNABC to the People's Republic of China in April, 1976.

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UPSIDE-DOWN

HOW DO YOU FEEL ABOUT... *working nights*



Recently *The Canadian Nurse* has published articles on the difficulties many hospitalized patients have in sleeping. These are 'patient' problems that the nurse on night shift may have to deal with. There are other problems — what might be called 'nurse' problems, — associated with night duty.

Contemporary experiments concerning physical and mental functions indicate a noticeable fluctuation in performance depending on the time of day or night of an individual's activity. Studies on circadian rhythms have led one author to write, "We are all more or less inept during the nighttime hours."

Most nurses are called upon to work night shift at some time in their career. At *The Canadian Nurse* we are interested in finding out how *you* feel about working nights. Please fill in the questionnaire on the following pages and mail it to:

The Canadian Nurse,
50 The Driveway,
Ottawa, Canada,
K2P 1E2.

We hope to draw some interesting observations from your answers so that we can share them with you at a later date. The questionnaire is simple and could be fun. If you have any further comments about night duty, or any suggestions, feel free to add them at the end of the questionnaire. We hope to hear from you.

1. Night shift

a) Do you work nights?
- ☐ 1. yes
- ☐ 2. no.

b) Have you ever worked nights?
- ☐ 1. yes
- ☐ 2. no

c) Do you work
- ☐ 1. on a ward
- ☐ 2. in a specialty care unit (I.C.U., P.A.R., Emerg.)
- ☐ 3. other (specify). . .

d) Do you work
- ☐ 1. full-time
- ☐ 2. regular part-time
- ☐ 3. casual part-time

e) Do you work
- ☐ 1. three eight-hour shifts
- ☐ 2. evenings and days
- ☐ 3. nights and days
- ☐ 4. twelve-hour shifts
- ☐ 5. permanent days evenings nights

f) Do you work
- ☐ 1. short periods of night duty (up to seven days)
- ☐ 2. blocks of nights (two weeks or more)

g) Do you prefer to work nights in
- ☐ 1. short periods
- ☐ 2. blocks
- ☐ 3. not at all

h) Do you work nights
- ☐ 1. because you want to
- ☐ 2. because you would rather work nights than evenings
- ☐ 3. out of necessity (e.g. hospital policy)
- ☐ 4. other (e.g. family) (specify)...

2. Rest

a) Do you have difficulty sleeping after night shift?
- ☐ 1. no
- ☐ 2. no more than usual
- ☐ 3. yes, sometimes
- ☐ 4. yes, most of the time

b) If yes, do you have difficulty
- ☐ 1. getting to sleep
- ☐ 2. sustaining sleep
- ☐ 3. both of the above

c) Do you sleep
- ☐ 1. less than four hours
- ☐ 2. more than four hours, less than eight hours
- ☐ 3. more than eight hours

d) Is it easier for you to sleep
- ☐ 1. in the mornings
- ☐ 2. afternoons
- ☐ 3. evenings

e) Do you sleep for
- ☐ 1. one long period
- ☐ 2. one short period
- ☐ 3. two short periods
- ☐ 4. in "snatches"

f) Do you ever take medication to sleep?
- ☐ 1. regularly
- ☐ 2. sometimes
- ☐ 3. rarely
- ☐ 4. never

g) Do you take medication to sleep while working nights
- ☐ 1. regularly
- ☐ 2. sometimes
- ☐ 3. rarely
- ☐ 4. never

h) Do you generally feel well-rested while working nights
- ☐ 1. yes
- ☐ 2. somewhat tired
- ☐ 3. no, very tired

3. Eating habits

a) Do you experience a change in your appetite while working nights?
- ☐ 1. yes, always hungry
- ☐ 2. yes, feel nauseated, not hungry
- ☐ 3. no
- ☐ 4. other (specify)...

b) Do you eat regular meals while working nights?
- ☐ 1. yes, three regular meals
- ☐ 2. yes, two regular meals
- ☐ 3. yes, one regular meal
- ☐ 4. no, snacks

c) Would you describe your eating habits while working nights as comparatively
- ☐ 1. unchanged
- ☐ 2. improved
- ☐ 3. adequate
- ☐ 4. poor

d) Do you experience significant weight fluctuation while working nights?
- ☐ 1. no
- ☐ 2. yes, weight gain
- ☐ 3. yes, weight loss

4. General activity

a) Do you find it difficult to carry on such functions as shopping, banking, keeping appointments, etc. while working nights?
- ☐ 1. yes, very difficult
- ☐ 2. moderately difficult
- ☐ 3. no problem

b) Do you...
- ☐ 1. interrupt sleep to maintain such activities
- ☐ 2. sleep and ignore such functions
- ☐ 3. other (specify)...

c) Do you keep in touch with friends and acquaintances during periods of night shift?
- ☐ 1. frequently
- ☐ 2. sometimes
- ☐ 3. rarely
- ☐ 4. never

d) Does working nights interfere with your family life?
- ☐ 1. not at all
- ☐ 2. not too much
- ☐ 3. yes, significantly

e) How do you feel that you interact with friends and family while working night duty?
- ☐ 1. as well as usual
- ☐ 2. not as well as usual

f) On your 'off' hours do you feel isolated or lonely?
- ☐ 1. yes, usually
- ☐ 2. sometimes
- ☐ 3. no, never

g) On your 'off' hours would you describe your mood as comparatively
- ☐ 1. cheerful
- ☐ 2. balanced
- ☐ 3. slightly low
- ☐ 4. depressed

5. At work

a) Do you feel comparatively alert while working nights?
- ☐ 1. most of the time
- ☐ 2. some of the time
- ☐ 3. not at all

b) Do you find it difficult to stay awake while at work on night shift?
- ☐ 1. no, never
- ☐ 2. sometimes
- ☐ 3. yes, especially at .....
(specify time)

c) Do you feel physically comfortable while working nights?
- ☐ 1. yes
- ☐ 2. no (specify). . .

d) Would you describe your thinking process as. . . while working nights
- ☐ 1. quick, clear
- ☐ 2. adequate
- ☐ 3. sluggish or foggy

e) Do you feel that your reflexes are
- ☐ 1. quick
- ☐ 2. jumpy
- ☐ 3. slowed somewhat
- ☐ 4. slowed considerably

f) On night shift, would you describe your reaction to stress situations or problems as
- ☐ 1. confident
- ☐ 2. less confident than usual
- ☐ 3. shaky

g) In relation to patients' emotional needs, how would you describe your reactions on night shift?
- ☐ 1. more empathetic, caring than usual
- ☐ 2. unchanged
- ☐ 3. less empathetic than usual
- ☐ 4. uncaring

h) Working nights, do you feel
- ☐ 1. as competent as ever
- ☐ 2. less competent than usual
- ☐ 3. incompetent

i) Working nights, do you generally feel
- ☐ 1. bored
- ☐ 2. lethargic
- ☐ 3. content
- ☐ 4. anxious
- ☐ 5. other (specify)...

j) Working nights, do you generally feel
- ☐ 1. euphoric
- ☐ 2. lightheaded
- ☐ 3. balanced
- ☐ 4. slightly depressed
- ☐ 5. miserable

k) Working with others on nights shift do you feel
- ☐ 1. open, communicative
- ☐ 2. relatively quiet
- ☐ 3. easily annoyed
- ☐ 4. withdrawn...

l) Do you feel that communication with day or evening staff is
- ☐ 1. productive
- ☐ 2. adequate
- ☐ 3. lacking
- ☐ 4. other (specify) . . . .

m) On 'quiet' nights, do you feel inclined to
- ☐ 1. talk to wakeful patients
- ☐ 2. tidy the ward
- ☐ 3. read patients' charts
- ☐ 4. knit
- ☐ 5. other (specify)...

n) Do you feel that most of your night duty functions are
- ☐ 1. necessary
- ☐ 2. filling time
- ☐ 3. unnecessary

o) When you finish a night shift, do you generally feel that your work has been
- ☐ 1. worthwhile
- ☐ 2. satisfactory
- ☐ 3. pointless

p) When you return home after a night shift, do you feel
- ☐ 1. cheerful
- ☐ 2. content
- ☐ 3. letdown
- ☐ 4. other (specify)...

Other comments and suggestions are welcome.

We look forward to sharing the response of other nurses with you. Thank you for your participation.

At Last...

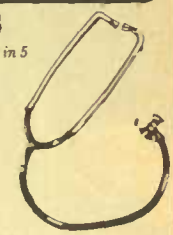


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Changes....

Awareness is, perhaps, the key to this second in a three part series on the cardiovascular system. Two and one half million Canadians suffer from hypertension and only one in four are receiving treatment. Whose responsibility is it to create a climate of awareness?

The patient who is waiting for cardiac surgery ... the MI patient whose life-style must change ?W ho helps them cope with these changes?





OVER AND OVER

Penny Jessop

Arterial Blood Pressure

The normal blood pressure fluctuates constantly, varying with environmental stimuli and personal response. Arterial blood pressure is regulated by intrinsic and secondary factors.

- *intrinsic components* include: blood volume, viscosity, arterial wall elasticity, cardiac output(referring primarily to left ventricular function) and peripheral resistance.

- *secondary regulators* include: the autonomic innervation of blood vessels through controls in aortic and carotid sinus moderator nerves, central and peripheral reflex centers, chemical mediators (epinephrine and norepinephrine), effects of respiration, venous return to the heart, and venopressor mechanisms.

For the details of these regulator mechanisms see Table 1. Normally, arterial pressure exists at its maximum level in the left ventricle during systole with a gradual lowering in left arteries, capillaries and veins until it reaches subatmospheric levels in the large veins during diastole. These fluctuations, known as arterial pulse pressures, can be indicative of the efficiency of the cardiac cycle, the mean atrial pressure, and arterial wall elasticity.

Blood pressure has a direct relationship with the cardiovascular system and other major body systems. Understanding arterial blood pressure involves the consideration of a number of physiologic variables. Unless our conditions of measurement are accurately defined, interpretation of hypertension may be imprecise.



Hypertension

Arterial hypertension can be defined as the elevation of blood pressure to a level which requires investigation and treatment. A relationship has been established between hypertension and left ventricular hypertrophy, aortic dissection, renal insufficiency, cerebral vascular diseases, and coronary artery disease.

Hypertension itself, whether essential or secondary, often carries with it no specific symptoms. An elevated blood pressure is itself a symptom of another problem. Headache, dizziness, fainting, tinnitus, and epistaxis may mark the more advanced development of hypertension. But diagnosis often occurs as a result of complications arising from hypertension. If it remains undetected, untreated, or if patients do not comply to treatment, it can progress to cardiac failure, cerebral thrombosis, and massive cerebral hemorrhage.

Essential Hypertension

Essential hypertension (primary, idiopathic) accounts for 90 percent of all cases of hypertension. The cause of the disease is not known, but research hints that it is not merely a result of the aging process.

The arterioles of the hypertensive person are narrowed. As arterial pressure mounts gradually to push blood through narrowed arterioles, hypertrophy of the smooth muscle of these walls will occur. In the cycle that follows, further narrowing develops thus increasing peripheral resistance and increasing cardiac work load. Narrowing also occurs in the vascular bed, with the result of impaired nutrition to the vital organs particularly the myocardium, kidneys, and central nervous system.

In advanced phases of accelerated hypertension there is widespread degeneration of the arteriolar wall — this is known as MALIGNANT hypertension, and is manifested in the ocular fundi as papilledema. Papilledema rarely develops without the presence of an underlying pathologic process.

Secondary Hypertension

Secondary hypertension accounts for ten percent of all known cases of hypertension, and is due to a known and generally manageable cause. Underlying etiology may arise with the following problems:

1. *disturbances in the central nervous system*
a) increased intracranial pressure i.e. neoplasm, inflammation
b) brain stem and spinal cord disease i.e. poliomyelitis

2. *disturbances in adrenal tissue*
a) pheochromocytoma
b) Cushing's syndrome
c) primary aldosteronism

3. *disturbances in the renal system*
a) renal artery obstruction
b) acute renal ischemia

Improved detection of individuals with hypertension over the past twenty years has had little effect on the mortality rates associated with the disease. For health professionals, an understanding of the dynamics of hypertension is only the beginning — the challenge lies in creating a climate of overall public awareness, and in setting up comprehensive programs for the detection and follow-up of people who have hypertension. Two of the following artlcles focus on a review of the pathophysiology of hypertension and of blood pressure recording; a third illustrates the implementation of a successful screening and follow-up program for the detection and treatment of hypertension, and tells how nurses got involved.

c) acute and chronic glomerulonephritis
d) pyelonephritis and others

4. toxemias of pregnancy

5. coarctation of the aorta

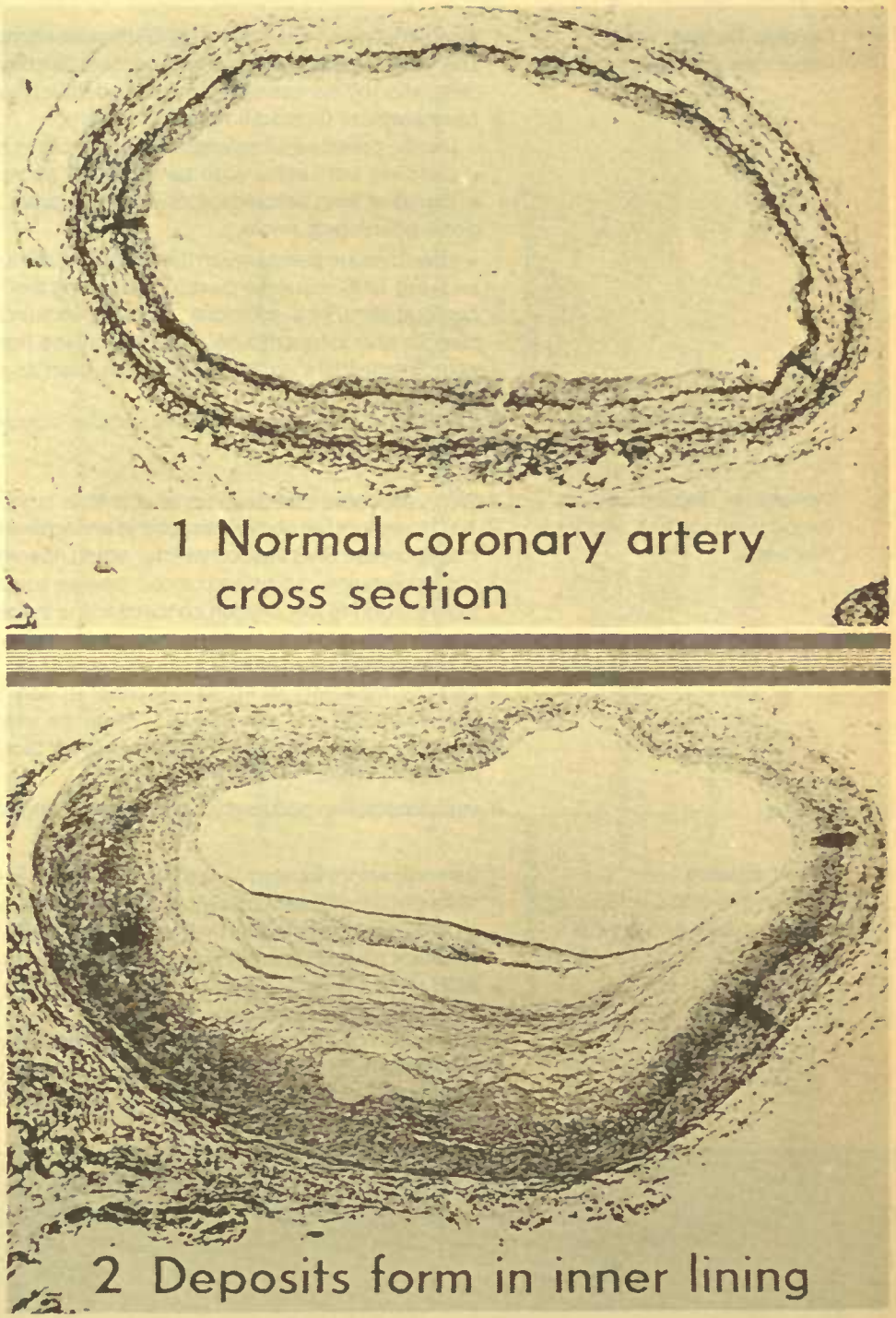
In these cases, treatment of the specific cause of hypertension results in its control.

Factors Affecting Hypertension

Treatment of hypertension is directed towards decreasing the patient's blood pressure as soon as possible. The nature of medical management depends on the evaluation of the patient. Certain factors must be kept in mind in the assessment and management of the patient with hypertension:

- the patient's age, sex, and race
- the degree of atherosclerosis
- any familial history of hypertension
- the degree of psychologic stresses and emotional lability
- any pre-existing damage to major organs i.e. congestive heart failure, uni- or bi-lateral renal ischemia, cerebral ischemia
- the degree of overweight or obesity
- the patient's smoking habits

The treatment and follow-up of patients with hypertension is a matter of great concern: untreated hypertension can result in serious cardiovascular, cerebral vascular and renal vascular complications.



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Table 1

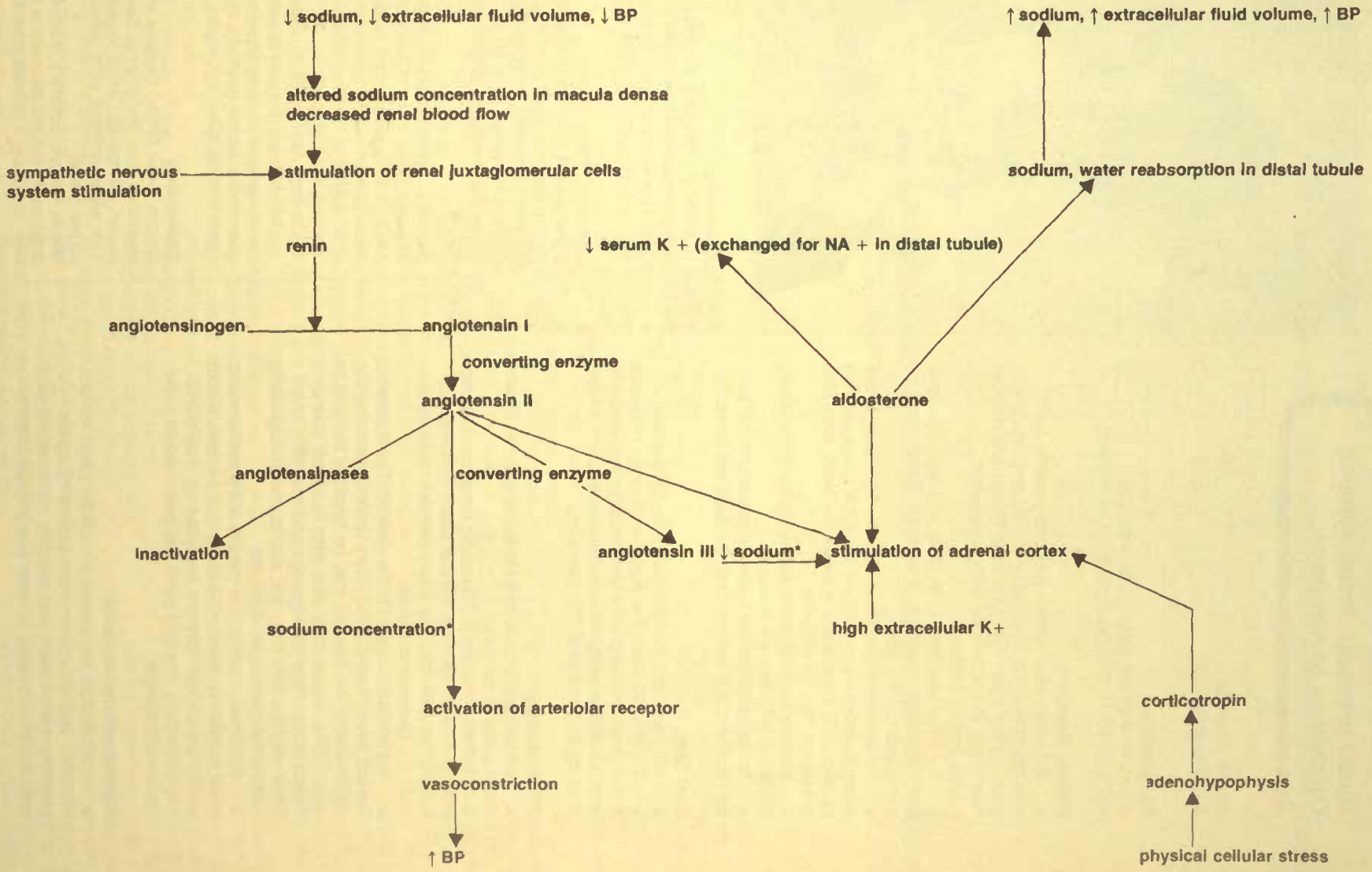
Blood Pressure: Physiologic Controls

Major determining factors	Mechanisms
Cardiac Output (heart rate and stroke volume)	1 sympathetic nervous system (SNS) impulses predominate in the Vasomotor center (VMC). The VMC is located in the pons and medulla oblongata and the lateral portion responds to stimulation by increasing heart rate, peripheral resistance and adrenal medulla secretions. 2 baroreceptors (pressure receptor cells): • ↓ aortic pressure stimulates baroreceptors in aortic arch • impulses from aortic arch sent to VMC via vagus nerve • impulses from baroreceptors in carotid sinus sent to VMC via Hering's nerve then glossopharyngeal nerve. • when these impulses reach the VMC, they stimulate the cardiac center in the medulla to increase SNS impulses thereby increasing the heart rate. 3 cerebral stimuli eg. emotions: propably stimulate the hypothalamus which acts on the medulla and autonomic neurons to increase heart rate and hence blood pressure. 4 neurotransmitters eg. catecholamines such as epinephrine and norephinephrine alter heart action. 5 a multitude of factors which affect stroke volume and cardiac rate exist.
Peripheral resistance (blood viscosity and arteriolar diameter)	1 SNS vasoconstrictor action predominates in the VMC. 2 baroreceptors (as above) respond to an increase in arterial pressure by sending impulses that decrease SNS vasoconstrictor action, thereby allowing for relaxation of the arterioles. 3 chemoreceptors: aortic and carotid arteries contain sensitive structures (chemoreceptors) that respond to low oxygen concentrations in the blood and alterations in blood pH. They stimulate the VMC to cause vasoconstriction, leading to an increased heartbeat and a rise in arterial blood pressure. 4 cerebral medullary ischemic response: At very low blood pressures, localized deoxygenation and elevated CO_2 stimulate vasoconstriction. 5 viscosity is determined by the number of red blood cells and plasma proteins found in the circulating blood. 6 vasoconstriction occurs through the renin-angiotensin mechanism. (See diagram 1).
Blood volume (changes in blood volume alter cardiac output and arterial pressure)	1 osmoreceptors located in the hypothalamus are nerve cells that respond to the osmotic state of the fluid surrounding them. In high extracellular fluid concentrations of sodium, fluid moves out of the cells and the osmoreceptors shrink. This increases their rate of firing to the posterior pituitary gland and increases the release of antidiuretic hormone. An increase in ADH results in water retention and therefore, increases the blood volume and results in an increased blood pressure. 2 restoration or alteration of fluid volume occurs also through the renin-angiotensin mechanism. Recent evidence suggests that an altered renin-angiotensin mechanism may be a factor in primary hypertension. (See diagram 1).

Source: Janice Goerzen and S. Darlene Abbott

Diagram I

The Renin-Angiotensin Axis: A Current Concept



* currently under study

Blood pressure measurement: Guidelines to accuracy

Janice Goerzen,
S. Darlene Abbott

Environment:
- quiet with the least stress possible.
- wait 10-15 minutes if patient has smoked.

Patient Position:
- BP taken after patient has been supine for 5 minutes, sitting for 5 minutes, immediately on quiet standing and again 2 minutes later. Postural differences may occur in accordance with physiologic compensatory reflexes.
- for initial readings, both arms and legs are used because of the possibility of vascular disease or coarctation of the aorta.
- for arm readings, place arm at heart level. If the artery is above the heart level, false low pressures may be obtained. If the artery is below the heart, false high pressures may be recorded.
- palpate brachial artery and apply the stethoscope firmly but with minimal pressure.
- for leg readings, the patient is prone with leg bent, and stethoscope applied over the popliteal fossa.

Cuff Size:
- it is important that the cuff is the proper size.
- if cuff is too small (i.e. if cuff width does not equal 2/3 of arm diameter or if the compression bag (bladder) is too small to encircle the arm adequately) then, a false reading as great as 60/30 can occur.

BP recording:
- inflate rapidly to 30 mm Hg above systolic (check radial pulse to be sure).
- deflate at the rate of 2-3 mm Hg per second. Do not stop and never reinflate without totally deflating and waiting two minutes. The artery needs time to recover from the previous pressure.
- the first sound heard is the systolic. The diastolic is the last sound heard. If the artery is compressed by the stethoscope, the diastolic may be heard all the way to zero. Compression may also alter Korotkoff sounds. These sounds are the tappings and murmurs heard while taking a BP. They are also useful in diagnosing certain cardiovascular diseases.
- controversy exists over the use of the muffle or end point as best representative of the true diastolic. If both points are distinct they are recorded eg. 120/80/70. Experimentally, the end point has been shown to be more reproducible.

Equipment maintenance:
- stethoscope ear inserts should be clean, cuffs repaired, aneroid manometers calibrated against mercury manometers and mercury manometers also checked for accuracy at least every three months.

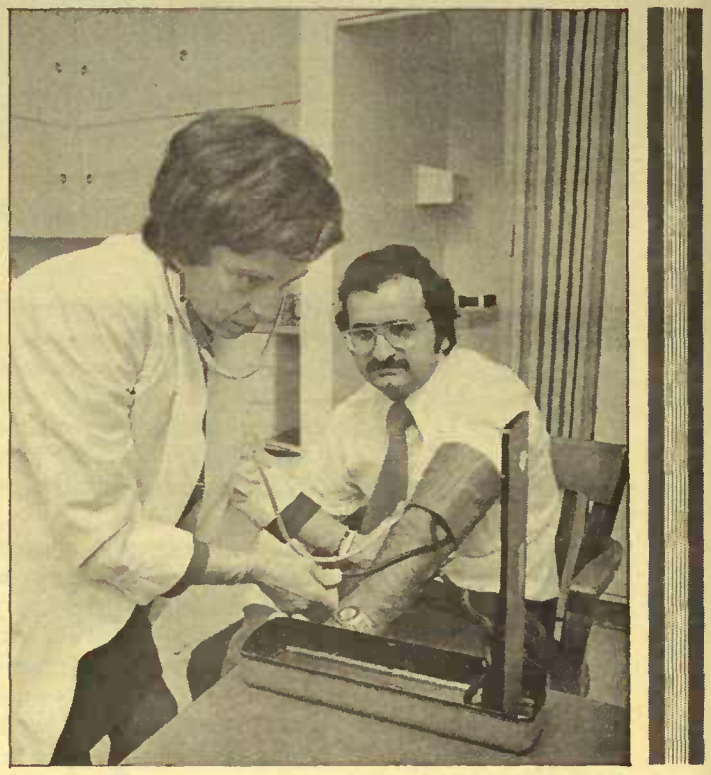


Photo by Health and Welfare Canada

Korotkoff sounds:
If there is difficulty hearing Korotkoff sounds, try the following measures to increase sound intensity:
- check that the stethoscope is located properly, that the cuff size is appropriate and the manometer is working.
- inflate the cuff more quickly
- have the patient open and close his fist about 10 times after the cuff has been inflated above systolic
- drain the arm of blood by elevating the arm for a few seconds before the pressure is taken.
- be aware that individual differences in hearing acuity exist.

Janice L. Goerzen, (R.N., Galt School of Nursing; B.Sc.N., U. of Alberta) is a Master of Medical Science student studying hypertension at the University of Calgary. She is co-author of Review of Maternal and Child Nursing, *C.V. Mosby.*
S. Darlene Abbott, (R.N., University of Saskatchewan) is a staff nurse with extensive cardiovascular nursing experience. She is the coordinator of the Foothill's Hospital hypertension clinic in Calgary, Alberta.

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It has been estimated that two and a half million Canadians have hypertension. Finding them can be a problem — their treatment, education and follow-up becomes a sizable task to those in a professional position to be able to do something to control the disease. Sizable, but not impossible....

Many people with hypertension go either undiagnosed or untreated. Over the past three years, in Edmonton and six small Alberta towns we have been successful in screening 63,000 people for hypertension, and in detecting and treating those in this group found to have elevated blood pressures. We have used volunteer nurses and a variety of community resources to create an active awareness of the existing problem. The following is a step-by-step account of our program for the detection, treatment and follow-up of those with hypertension. The results speak for themselves.

SEVEN STEPS

to a Successful Hypertensive Screening Program

Donald S. Silverberg, M.D.

1

Alerting the medical community

- At the beginning of our program, we obtained the support of the Alberta Medical Association. This strategy proved beneficial when individual physicians became antagonistic at our "storefront" medicine.
- We distributed to all physicians a summary of recent advances in hypertension, including guidelines for investigation and treatment.
- We arranged conferences on hypertension at all the Edmonton hospitals and we went out and spoke to the physicians and nurses in the small towns.

2

Finding volunteers

- We spoke to nursing associations, nursing alumni and public health nurses, both in Edmonton and in the six small towns, and had an excellent reception. Hundreds of nurses volunteered their time. Our training programs for these nurses included lectures on hypertension and a review of the technique of blood pressure measurement. The nurses were required to pass a test for accuracy of blood pressure measurement before they could participate in the project.

3

Finding places for screening

- Shopping center managers were most cooperative in finding us busy places in their shopping malls and in obtaining free booths for taking blood pressures. They also advertised the project in their monthly newsletters to their customers and on radio and television.
- After we addressed the local pharmacy association in Edmonton, 30 pharmacists set up blood pressure detection booths in their drug stores. Only three manned the booths themselves. The remainder had nurses do the screening.
- We approached occupational health nurses in various businesses and in the Provincial Government. These nurses helped to find suitable areas for our screening program and advertised the project among their employees. This included placing announcements about the project in employee's pay envelopes.
- We approached Edmonton high schools and colleges and received their permission for screening. In high schools, lectures and demonstrations about hypertension were given by nurses to each senior class, and pamphlets were distributed to all the students. We screened 15,000 high school students, about two-thirds of the total high school population.
- In the small towns, sports arenas were used for hypertension detection clinics, as well as drug stores and shopping malls.
- Nurses attended meetings of various associations (Rotary, Kiwanis, etc.), spoke on hypertension, and took the blood pressures of all those attending.
- In one small town, a mobile van was used for screening. This was moved from one location to another during a three-week screening program.

4

Creating public awareness

- Throughout the past three years, over 40 articles on hypertension have been published in the Edmonton newspaper. Similar advertising took place in small-town *newspapers.*
- Hypertension experts spoke on several "talk" shows on *TV and radio. Posters* were set up throughout the towns and the city, advertising the project and explaining hypertension.
- Community meetings about hypertension were extremely well-attended in Edmonton and in the small towns. At those meetings, doctors and nurses spoke about hypertension, answered people's questions and took blood pressure measurements of those attending.
- Both in Edmonton and in small towns we contacted members of local and provincial governments. Such *community leaders* came, with press fanfare, to have their pressures taken and at the same time, made public statements encouraging

participation in our project. Organizations such as the Rotary Club, the Chamber of Commerce, etc., were contacted, and they encouraged their members to attend the screenings. Blood pressure teams visited many of these groups (including the Provincial Cabinet) to take blood pressures at the meeting itself.

- In one town, volunteers telephoned people on the *voters' list* to announce the project and tell people what hypertension was; in response, 60 percent came for the screening. In another town where this was not done, only 30 percent came. In the first town, those 40 percent who did not come to the initial screening were called again, and another 16 percent of the town came to a second screening.
- At the time of screening, two blood pressures were taken, five minutes apart, and a short questionnaire was filled out. There was ample time for people to ask specific *questions* about hypertension. Several *pamphlets* on hypertension (both Merck, Sharpe & Dohme and Searle pharmaceutical companies have excellent pamphlets, as do the Kidney and Heart Foundations) were handed out free of charge.
- Those screened were handed one of two *cards*. Those whose blood pressures were normal, were handed a card which said so and showed them their values as well as the normal values for their ages. Everyone whose systolic or diastolic pressure was elevated on both blood pressure readings, received a card to this effect, which indicated the specific reading as well as normal values. This card explained that the high reading at this time did not necessarily mean the pressure was permanently elevated. However it requested that the individual visit a physician for further checking.

Figure I

Age	under 40	40-64	over 6
Systolic	⩾ 155	⩾ 160	⩾ 165
Diastolic	⩾ 95	⩾ 95	⩾ 100

5 **Maintaining a follow-up program**

- Volunteers telephoned those who had been found to have elevated pressures at the time of screening. They called 3 months, 6 months, 12 months and 24 months later to check whether or not a physician had been consulted and, if so, what he had done. If medication had been started, the volunteers asked whether treatment was being continued and, if not, why not. One and two years after the screening the physicians were contacted by letter to find out how well the individual's blood pressure was being controlled. Perhaps through these contacts physicians became more concerned.

6 **Recognizing problems**

- For our criteria for hypertension see Figure 1. Generally physicians did not treat systolic hypertension or diastolic blood pressures of 95 to 99 mmHg. Several studies throughout the world are currently investigating whether treatment of these groups is, in fact, worthwhile. It is the author's opinion at the present time that a diastolic pressure of ⩾ 95 mmHg at screening should be used as the criterion for hypertension.
- Physicians generally used cuffs of only one width. This is a practice that needs to be questioned since standard cuffs may result in falsely low readings for those with thin arms and high readings for those with wide arms. In our screening program we used blood pressure cuffs of different widths, depending on the width of the person's arm.

7 **Considering other possibilities**

- We undertook a survey of many medical specialists in Edmonton. The majority of them (opthalmologists, otolaryngologists, dermatologists, psychiatrists, surgeons, etc.) did not routinely take their patients' blood pressures. An educational drive directed at them and nurses working in their offices might produce an excellent source for hypertension detection.
- Only one of six adults admitted to the Emergency department of the University Hospital in Edmonton has his blood pressure taken. It is the author's personal belief that hospitals should require that the pressures of their emergency patients be routinely taken and that patients be informed if pressures are elevated. Those that do not routinely do so should lose accreditation.
- In a study we did of 500 adults screened in dentists' offices in Edmonton, two percent had pressures of ⩾ 160 and/or ⩾ 100 mmHg. When they were referred to their doctors, the dentists' readings were verified by the doctors' readings in almost every case and several patients were put on treatment. Dentists have a high stake in detecting hypertension. If they should use vasopressors for tissue retraction or do any type of dental treatment for someone with uncontrolled hypertension, they could precipitate a vascular catastrophe.
- Public health nurses, occupational health nurses, blood bank technicians, physiotherapists, chiropodists, chiropractors, firemen and other groups could also take blood pressures. We are now working with unions to get their members checked for hypertension.

In Edmonton, we have screened 55,000 people of a population of 500,000; 8,000 people from the six Alberta towns have been tested. In both Edmonton and the rural areas, six percent of the people screened were found to have elevated blood pressures and were not being treated at the time of detection. Evaluation of the results of our program can be seen clearly in the figures that follow:

- 90 percent of the group found to have elevated pressures went to see their doctors as a result of our screening program
- 40 percent of those who went to see their doctors were started on treatment
- eighteen months after treatment was begun, 90 percent of those who were to stay on treatment have done so
- of those who stayed on treatment, 65 percent have achieved blood pressures of < 160 and/or < 95 mmHg, and 15 percent of 160-169/95-99 mmHg.

Why have we been so successful? We don't really know, but maybe some of the tactics we used have helped to contribute to our success.

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What patients want to know about their PACEMAKER...

Authorities estimate that there are close to 300,000 people in the world today whose lives depend upon the "electronic heart stimulation" supplied by an implanted pacemaker. For these people, their electronic pacer is the key to living a full and active life. It is only natural for them to have many questions about the device that enables them to lead a normal life. The Ontario Heart Foundation has published a booklet that answers many of these questions. It is called "You and Your Pacemaker" and is available from the Foundation. Excerpts are reprinted here with their permission to help you as a nurse become more aware of these concerns and to be able to offer informed support and encouragement.

The concept of electrical stimulation of the heart was first introduced in Toronto by Dr. Wilfred G. Bigelow and his associates in 1950. It was not until 1960, however, that the first miniaturized, self-contained electronic pacemaker was implanted in a human being. Since then new pacemaker models with improved circuitry have helped both adults and children with a wide range of heart problems.

The normal heart is regulated by a natural timing device which sets the rate of the heart by producing an electrical signal, causing the muscle of the heart to contract and relax, pumping the blood and setting up waves of pressure which can be felt at various parts of the body as a pulse.

Not every heart, however, functions properly. If the pathway carrying the natural pacemaker signal is blocked either intermittently or permanently, we have a condition known as "heart block."

If the heart block is complete, the natural pacemaker signals are not transmitted in the heart and the pumping rate may slow to 30 to 40 contractions per minute. This low rate continues because the lower half of the heart does generate some signals of its own. In intermittent heart block, a fraction of the natural pacemaker signals are transmitted, making the pulse slow and irregular.

To restore normal pacing to the heart and overcome either intermittent or complete heart block, an artificial pacemaker (sometimes referred to as a pacer) is implanted and takes over the work of the natural pacemaker by sending an electrical signal into the heart muscle, causing contraction and relaxation in the same manner as a natural pacemaker. For patients who have a complete heart block, a "fixed rate" (or asynchronous) pacemaker system is often implanted. This pacemaker sends a steady fixed electrical signal to the heart at a rate pre-selected for the patient by his doctor — for example, 70 beats per minute.

For patients with intermittent heart block, who do have some normal heart pacing, a "demand" (or inhibited) pacemaker system is implanted. This pacemaker remains inactive as long as the heart rate is normal. If however, the heart rate drops below the pre-set rate, the demand pacemaker takes over and maintains an adequate heart rate.

Q. What are the components of a pacemaker?

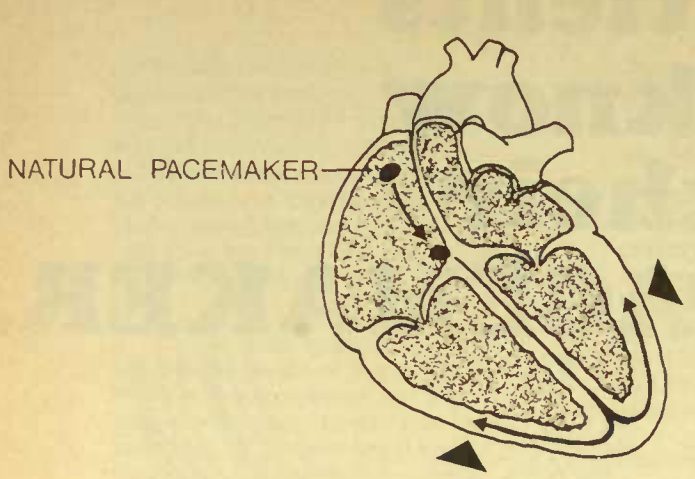
A. An electronic pacemaker consists of two parts, 1) the pulse generator (or battery pack) which contain the circuitry and batteries that generate the electrical signal, 2) the lead(s) (or electrodes) which carry the electrical signal from the pulse generator to the heart.

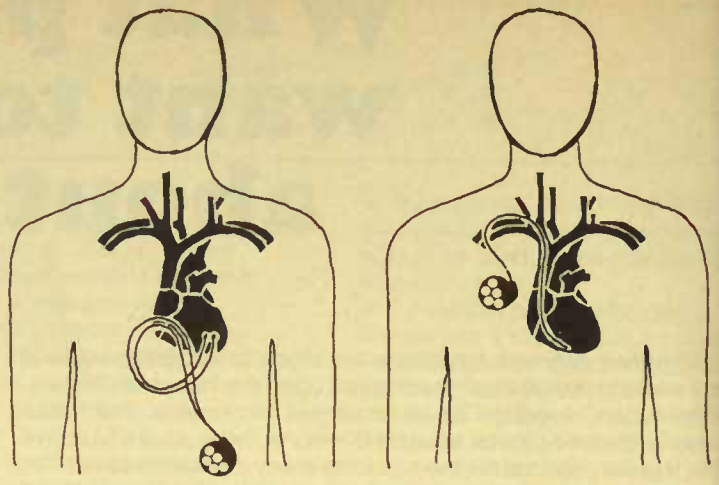
Q. Where is the pacemaker implanted?

A. There are normally two sites for the implanted pulse generator. 1) When the leads are attached directly to the *outside* of the heart, the pulse generator is usually implanted in the abdominal wall. This is referred to as an "epicardial" or "myocardial" implant. 2) When the leads are inserted through a vein in the neck or shoulder to the *inside* of the heart, the pulse generator is usually implanted under the skin just below the collarbone. This is referred to as an "endocardial" or "transvenous" implant.

Q. When is the pacemaker replaced?

A. Since the batteries in the pacemaker will run down with time, mechanisms have now been established to determine when the power source must be changed. This is done by a continuous follow-up of the patient by visits to a Pacemaker Clinic, or his personal physician or cardiologist where electrocardiograms will be taken and compared to those taken on previous visits. Initially, after implant, patients will be checked every three to six months. As the time increases and nears the predicted life of the battery cells, visits will be scheduled more frequently. A fairly recent innovation is telephone monitoring whereby a patient can telephone a Pacemaker Clinic and, using a special transmitter, can send an electrocardiogram by telephone. This is recorded by a tape recorder and then read by the physician or cardiologist and compared to previous electrocardiograms. Such telephone monitoring can be used by patients when on holiday and at a distance from a Pacemaker Clinic or their doctor. Similarly, it can be used by doctors and patients in outlying areas by calling a centralized or local Pacemaker Clinic. Careful monitoring assures the patient that the pulse generator will be replaced *before* failure occurs, thus preventing a recurrence of fainting spells and a very low pulse rate. The time between initial implant and replacement is being constantly lengthened. Pacemaker manufacturers are continually striving through research to obtain longer life from the pacemaker.





Q. What is the power source in the pulse generator?

A. The power source, necessary to provide the electrical signal to the heart is provided by battery cells. There are four main types of cells presently in use. Mercury-zinc cells last on the average of about 30 months. Nickel-cadmium cells may last from 5 to 10 years but must be recharged by the patient every few weeks. The lithium cells are a recent development and it is hoped will also last 5 to 10 years, but not enough data has been accumulated as yet. The nuclear cells of plutonium could possibly last a lifetime.

Q. How does a surgeon or cardiologist know what type of pacemaker to use and what manufacturer's product is most suitable for the patient?

A. This decision is based on the physician's knowledge of (i) the patient's heart condition and general health, (ii) the various pacemakers available and their use, and (iii) his experience and the experience of other physicians regarding the reliability and performance of these products.

Q. How are the battery cells replaced?

A. The battery cells are sealed in the pulse generator and when the batteries must be changed, a complete new pulse generator is implanted. This is a relatively simple operation. An incision is made over the pulse generator, the old unit is removed, the new pulse generator connected to the existing leads and re-implanted in the pocket formed by the previous unit. The wound is then stitched. This operation is usually performed under a local anesthetic and should not require more than one or two days stay in hospital.

Q. Should I feel any discomfort with my pacemaker?

A. At the outset, you will feel the discomfort of the incision and stitching and will be aware of the pacemaker in your body. When the wound heals, you should feel little discomfort and will lose your awareness of the pacemaker.

Q. What physical activity may I now enjoy?

A. In general, your level of activity is determined by your particular heart condition and can be only improved by a pacemaker implant. In the first few months the patient should avoid sudden stretching or reaching with his arms to prevent dislodgement of the leads from his heart. This does not apply to younger children or to those who have the electrodes attached directly to the heart from an endocardial implant. After this initial period and insofar as the pacemaker is concerned, you can bathe, swim, fly, drive a car, golf, curl, play tennis, lawn bowl, dance, run or jog — whatever activity you have enjoyed. It is suggested that heavy body contact sports be avoided as this could damage the leads or pulse-generator. *Do* consult your doctor if you wish to engage in such sports.

Q. What is an "Implanted Device Identification Card?"

A. After the surgeon has implanted the pacemaker, he will advise the manufacturer of the type and serial number of your pacemaker, the type of leads, your name and address, your physician's/surgeon's name and address, and date of the implant of the pacemaker. Shortly thereafter you will receive a card from the manufacturer with all the above information recorded. This card is an "Implanted Device identification Card" and should be carried with you at all times, to identify you as a pacemaker patient.

Q. Should I avoid various types of electrical equipment and, if so, which ones would cause the main problem and why?

A. No. Electrical interference is *not* a major problem with *modern* pacemakers. A demand pacemaker is designed to sense the natural electrical activity of the heart, but it may, under unusual circumstances, also sense other types of electrical energy. Theoretically this electrical interference could possibly alter the performance of the pulse generator, and you could feel faint or dizzy. Simply moving away from the electrical equipment will restore the pulse generator to normal operation without harm to the pacemaker. This problem has become negligible with proper shielding and improved pulse generator designs. Standing close to microwave ovens, arc welders, and large electrical generators *may still provide potential hazards* to pacemaker wearers. Standard household appliances, electric shavers, hair dryers, electrical lawn-mowers and power tools can be used with safety.

Q. Can I continue normal sexual activity?

A. Yes, in most cases.

Q. Should I avoid weapons detectors at airports?

A. According to a recent study, weapons detectors used at major airports will not affect the operation of a pacemaker. They will detect the presence of the pacemaker. You should be prepared to show your Implanted Device Identification Card. This card, too, will usually allow you to bypass the walk-through weapons detector if you ask to be scanned by a hand scanner.

Q. What drugs should be taken or avoided?

A. This should be fully discussed with your doctor and cardiologist.

Q. Is it necessary to take my pulse daily?

A. It is suggested that you take your pulse at regular intervals. You will be advised of your pulse rate after you have had your implant and before you leave the hospital. Should you detect a change, particularly a drop in rate, immediately call your doctor, cardiologist or the Pacemaker Clinic that you attend. If they cannot be reached, go to the hospital. To be sure that there is a measurable change in rate, rest for about five minutes and take your pulse again. If your pulse rate should rise, again recheck your pulse, and if it remains at this rate follow the procedure outlined above.

Q. How do you take your pulse?

A. Place the fingertips of one hand on the inside of the wrist of the other hand above the thumb. Avoid squeezing the wrist. Press just hard enough to feel your pulse. Count the pulse beats for a full minute using a watch or clock with a sweep second hand. This will give you your heart rate. In babies or small children, it may be necessary to use a stethoscope to listen to the beat of the heart and count the heart rate. This is something parents can easily learn to do.

Q. Whom should I advise that I have an implanted pacemaker?

A. When admitted to a hospital for other than a pulse generator change, inform your doctor, surgeon, anesthetist and/or nurses that you have a pacemaker. You should also advise your dentist as they too use equipment generating large electrical fields. If he has any concern, ask him to put a lead blanket over the pacemaker. Many patients who have pacemakers wear a Medic-Alert bracelet or necklace or similar identification in case of an accident. In Canada, these identification bracelets may be obtained from the Canadian Medic-Alert Foundation Inc., 174 St. George St., Toronto, Ontario M5R 2M9.

Q. What is the function of a Pacemaker Clinic?

A. The function of a Pacemaker Clinic is to follow pacemaker patients by regularly scheduled visits to the Clinic for electrocardiographic, electronic and x-ray analysis and comparison of data with previous records. Results of your visit are sent to your doctor and cardiologist. The Clinic is not a substitute for visits to your doctor or cardiologist, but rather supplies additional information concerning the function of the implanted pacemaker system.

Q. Do I need the service of my physician and my cardiologist as well as the Pacemaker Clinic?

A. Yes. It is suggested that you regularly visit your physician for your general health and perhaps visit your cardiologist annually. Results of your scheduled visits to a Pacemaker Clinic will be sent to your physician and your cardiologist.

Q. If I move to another city or town and have to change doctors, what do I do?

A. Once you have selected a new doctor and have advised him that you have a pacemaker, ask him to request all the information from your former doctor or Pacemaker Clinic.

Q. What other symptoms related to problems with my pacemaker implant should I be aware of?

A. If you experience difficulty in breathing, blackouts, dizzy spells, prolonged weakness or fatigue, swelling of limbs, palpitations or chest pains, *do advise* your doctor. Also, if you have a fever with tenderness, redness, swelling and/or discharge at the surgical scar, immediately contact your doctor.

Q. Can the pacemaker be rejected by the body?

A. A pacemaker is enclosed in a plastic or metallic case which has been shown to have minimal reactions to body tissues. However, just as some people are allergic to some specific external materials or products, so some people have a reaction to the plastic or metal casing of the pacemaker. *It is emphasized that such a reaction is minimal.*

Q. A great deal has been written about nuclear-powered pacemakers. What are the advantages and disadvantages of this pacemaker system?

A. Plutonium, the nuclear power source for this pacemaker has the potential to power a pulse generator for 40 years or more. However, it is not known how long the electrical circuitry and other components in a pulse generator will last; nor is the full effect of nuclear radiation yet known. The cost of the nuclear pacemaker is three to four times that of conventional battery cell powered pulse generators. Patients who have had nuclear pacemaker implants must also register with the Canadian Atomic Energy Commission and any country outside Canada that they may wish to visit. Nuclear pulse generators are designed to be used for the youngest patient due to the added duration of power which this source offers. Because of the above reasons, the Ontario Department of Health and the medical profession are proceeding very carefully in the implanting of nuclear-powered pacemakers.

Q. Can my pacemaker fail?

A. Any man-made device can fail, but many precautions are taken to prevent failure. Pacemaker manufacturers carry out stringent testing procedures both during and after production of their product. In addition, checking by your physician, cardiologist, or Pacemaker Clinic alerts them to possible early failure such as breaks in the leads, electronic malfunction or premature battery failures.

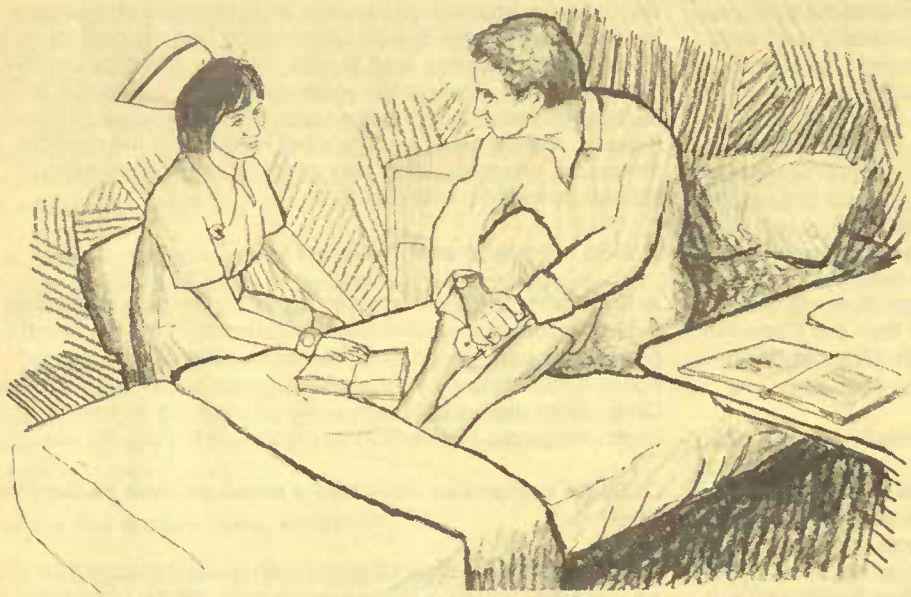
Q. Some companies have had a recall on their pacemakers. Why?

A. It was previously stated that any man-made instrument can fail. If a significant number of failures occur in any model of a pacemaker, then a recall can be ordered by the Bureau of Medical Devices, Health and Welfare Canada, or can be initiated by the manufacturer. There is excellent cooperation between the manufacturers, the medical profession, and the hospitals and when a fault does appear with any pacemaker, the manufacturer sends out word to the medical profession that they should be on the lookout for faults in specific models. On the other hand, if the doctors or hospitals find faults occurring, they then alert the manufacturer.

You and your Pacemaker *was published with the medical, educational and financial support of the Ontario Heart Foundation's Public Education Committee. The booklet was developed and researched by Ron Gorrie, a member of the Toronto General Hospital's Pacemaker Club, and an active volunteer with the Ontario Heart Foundation's Public Education Committee. Gorrie, himself a pacer wearer, based the work on information he gained from research into commonly asked questions of pre- and post-insertion pacemaker patients. His own experience as a pacemaker patient has enabled him to recognize the many areas of concern for those depending on pacemakers.*

Mary Rakoczy

Waiting for Cardiac Surgery



Investigation indicates that patients who are waiting for cardiac surgery react according to an identifiable pattern as the appointed day draws closer. Understanding these thoughts and feelings makes it easier for the nurse to communicate with the candidate for cardiac surgery at each stage in the waiting period.

Historians call this the age of space. For surgeons it is the age of cardiac surgery.[1] Improved diagnostic tests, safer methods fo delivering anesthesia, and mechanical devices that substitute for heart and lungs enable the surgeon to perform more sophisticated procedures in an attempt to correct cardiac disease.[2] Today, thousands are alive as a result of such procedures. Unfortunately, however, most patients find their admission to hospital an unfamiliar, stressful, and sometimes frightening experience. A patient facing heart surgery may see it as a devastating blow to himself and to his family.[3]

This paper, attempts to identify the nature of the thoughts and feelings of patients in the waiting period prior to cardiac surgery and the subsequent implications for nursing care.

The study

Preliminary foci were established by interviewing the eleven patients in this study. In general, the content areas that were not mutually exclusive encompassed the patients' descriptions of their response to the idea of cardiac surgery and knowledge of it, their concerns, adaptive behaviors, and method of coping with the period of physical preparation.

Patients considered their situation in a seemingly identifiable sequence during the 72 hours prior to surgery. The emerging composite profile showed that particular types of thoughts and feelings predominated at different points in time relative to the day of surgery. Their nature and the order in which they appeared were reflected in the four

hases, or periods, identified in the model confrontation, self-reflection, resolution and ountdown).

This model (Figure 1) permitted a omprehensive description of the thoughts nd feelings of patients, but not every patient rogressed through all the phases identified.

Confrontation refers to the period when atients came face-to-face with the reality of he impending cardiac surgery.

They made four identifiable types of tatements referring to this period: reasons, oncerns, knowledge and support. Patients ave reasons to justify or explain the rthcoming surgery and expressed concerns hat revealed their interests and engaged their ttention. Some included the amount and type f information they had about the impending urgical procedure. And lastly, patients eferred to the assistance or support provided y individuals that had been helpful in dealing vith the impending threat of cardiac surgery.

Self-Reflection describes the period vhere patients contemplated their situation and tried to explain or justify the cause of their heart problem. They also talked about personal losses engendered by their problem, for example, they referred to having been deprived of something they had had previously.

Resolution refers to a period where statements made by patients focused on the process of internalizing the meaning of the surgery and incorporating this into their self-concept. Patients indicated they had resolved to go through with the surgery and stated their belief that what is desired is also possible.

Countdown refers to the day prior to cardiac surgery when the time remaining was counted off in fixed units.

The patient

Mr. Linder, a 52-year-old airline executive, was the father of four teen-aged children. He had had "heart trouble" for 18 years and stated that, "by June of this year I had all I could take." When I met him during the "waiting period" he felt he was getting worse and said that in February he had been "almost wiped out" by a serious heart attack. Mr. Linder progressed through all the phases identified in the study.

Confrontation

Mr. Linder had no difficulty expressing himself. Confronted with the reality of the impending cardiac surgery, he verbalized both his anxiety and disbelief:

> *I'm anxious about the idea of open heart surgery. (silence) So, now, I'm going to have heart surgery. (sigh) That's a pretty difficult pill for me to swallow but it's something I'm going to have to get used to ... and fast.*

Mr. Linder gave reasons for needing surgery and seemed to try to justify or explain it. He saw himself as having no alternative; his medical condition was such that this was the "last resort."

Patients expressed concerns in four areas. They verbalized their feelings of helplessness and/or fear of impairment, the

Figure 1

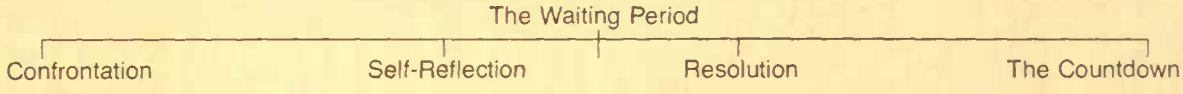
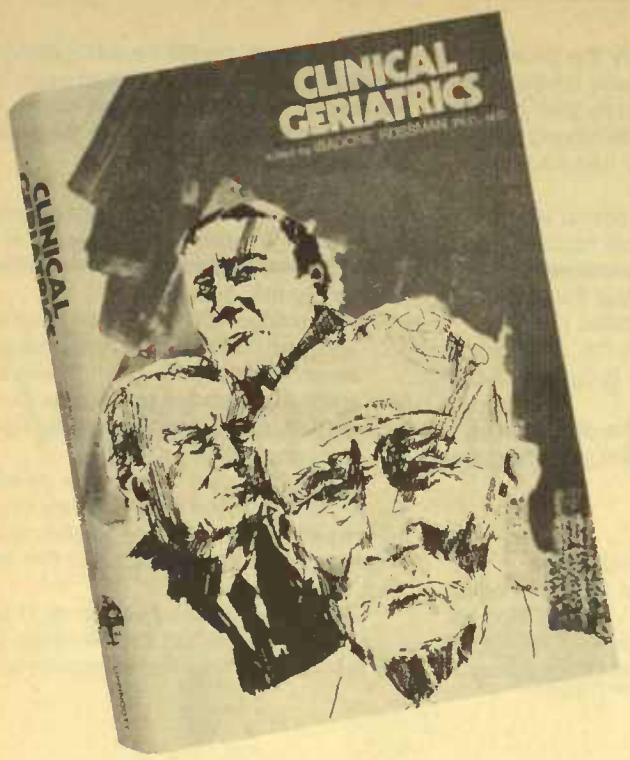


Table 1

Summary of Expressed Concerns

Concern	No of Patients Who Expressed Concerns: First Interview (Time 1)	Second Interview (Time 2)	Total
● *Feeling of Helplessness*	10	1	11
● *Fear of Impairment*	8	2	10
● *Seriousness of the Surgery*	6	3	9
● *Fear of Dying*	4	4	8

Concerns are those expressed by patients during the first and second interview. Time 1 *refers to the first interview;* Time 2 *refers to the second interview. Most patients were in the "confrontation" phase at* Time 1 *and "countdown" at* Time 2.



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By Janet M. Long, R.N., M.S. With 13 Contributors.

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11

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By Robert Kastenbaum Ph.D., and Ruth Aisenburg, Ph.D.

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9

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seriousness of the surgery, and/or their fear of dying. (Table 1)

Mr. Linder talked about his fear of dying. He said:

You know, I'm really concerned with the whole dying aspect of it. I feel very positive, but I still think anybody in my position thinks about it. Every operation has its risks. I figure I might die and that's it. It can happen to anybody anytime but...

He said that he had put his will in order before coming to hospital and often mentioned that his family still needed him.

The knowledge patients had about their impending surgery varied from minimal to extensive; only two patients had detailed information. Mr. Linder was one of them. He said:

The doctors propose to do a bypass on me. They are going to strip a vein out of my foot and then bypass the diseased area... One of the arteries has lost 95 percent of its efficiency. The major problem in my case is near the juncture of the left anterior descending and the circumflex. The one affected is the left anterior descending. Now that one is operative. They can tell from the angiogram that this one can be done... The bypass will be done straight from the aorta to at least an inch beyond the diseased area. The other major artery affected is the right coronary and that is affected in several areas. That one caused the original infarct and whether that bypass can be done is questionable... But the heart is going to develop its own bypass system and the circumflex will be feeding the muscle tissue.

Mr. Linder was often aggressive in that he would control the conversation, and it was difficult to keep him on topic. He expressed his lack of confidence in the doctors and nurses several times and said he enjoyed "stumping them with questions" and he was sometimes "flabbergasted by their answers."

In referring to support during the "confrontation," eight patients expressed confidence in their doctor. This was conceptualized as supportive in nature. Mr. Linder, was representative of this group:

The doctors here are good and I know I'll get good backup. Knowing that, well, that makes me feel good.

His confidence in the technology also helped him face the idea of surgery.

Family members played a supportive role for Mr. Linder and he appeared to have a close relationship with them; his expressions were loving and he smiled when he talked about them.

Mr. Linder also made reference to a successful patient, one who had had cardiac surgery and was "better off now than he ever was." This seemed to be yet another means of support, as this person was "living proof" that the surgery was, in fact, successful.

Self-Reflection

Mr. Linder tried to explain or justify the cause of his heart problem. He attributed it to being overweight, to high blood pressure, and to stress associated with his work. He stated:

I have some theories about my own case. I cannot speak for anybody else. I had my first infarct in 1966. I had no previous history of a heart condition. There were no symptoms except that I was overweight by about 14 kilograms and I have always been so. Also, my blood pressure tended to be on the high side. And last but not least... commitments to the job. That, I think, is responsible for most cardiac problems. I hear a lot of talk about dietary things but I question that. I believe stress has more to do with it than diet. Diet may be a contributory factor, but stress is a major factor because stress changes the electrolytes in the systems.

Resolution

In the "resolution" period Mr. Linder was "talked out" and said:

I can't ask any more questions because it's all been explained to me (pause) so I just sort of sit and wait for tomorrow."

Countdown

Time passed almost unbearably slowly for Mr. Linder during this "countdown" period. He often checked his watch, and once said:

Well, that's my life up to 9:03... My God, how the time drags.

Mr. Linder restated his confidence in his doctor during this period:

Dr. Myles is good ... I'm glad I have him.

The day prior to cardiac surgery, he also sought out a successful patient to converse with. He recounted the following:

Yesterday I went to visit Peter Price. He had surgery five days ago ... I just wanted to talk to him ... to see how he was doing. He did more for me than 10,000 chief surgeons and all the documentation in the world, because that was living proof.

In the "countdown," routine procedures were important to Mr. Linder:

Today is going to be one of those days that goes on and on and on, but I suppose they will keep me busy. I appreciate that because I know it won't be done in a haphazard way... that gives confidence... this routine... this logical sequence.

Implications for nursing

Mr. Linder, as one of the eleven patients in the study, illustrates a number of points important to nursing.

- During the *confrontation* period, when patients realize with shock the seriousness of having cardiac surgery, the nurse may help maintain hope by allowing them to express their feelings.
- When patients feel they have no alternative but to undergo surgery — "a last resort" — many are bolstered by a feeling of confidence in the doctor. The nurse may further support them by expressing her own confidence in the medical team and the technology involved.
- When expressed concerns center around the patient's feelings of helplessness and fear of impairment, the nurse may indicate her confidence in the medical team .
- The amount of knowledge about the impending surgery varies from patient to patient. Only two in this study had detailed information and only one patient asked for more detail, particularly about the surgical procedure. This suggests that not all patients require or desire a great deal of information in the preoperative period.

As nurses, we need to reexamine our teaching plans. Is our teaching still based on what we *think* patients should know, or on the needs of individual patients? Is it crucial, for example to teach deep breathing and coughing? If so, how and when? We need to find out how patients learn in the preoperative period when they think and feel as they do.

- In the *confrontation* period, when patients talk about their families and show an interest in having them present , the nurse needs to be aware of the importance of families to patients. Supportive relationships can help minimize anxiety by reducing a patient's feelings of alienation from those who are meaningful to him. For example, rules for visiting hours may be appropriately bent or discarded.
- When patients in the *confrontation* period, refer to the importance of seeing or hearing about similar cases, the nurse can instill a sense of confidence by providing examples of her former patients who have had successful operations. Later, in the *countdown*, patients themselves actually search out these successful patients without the aid of the nurse. The nurse can best assist by being aware of this and allowing patients to do this on their own.
- As patients move on to *self-reflection*, they indulge in what appears to be self-pity or grieving, suffer feelings of guilt, and mourn their loss of control. The nurse needs to recognize the importance to patients of this period of grief. She can assist by encouraging patients to verbalize the felt losses and their causes since it has been demonstrated that talking does help and that "if grieving is blocked, the patient then has to adopt some defensive sort of adaptation rather than clear the site to reconstruct the ego."[4]
- The *resolution* period is characterized by expressions of hope of recovery, rebuilding of confidence and self-esteem, and the decision to go ahead with the surgery. Patients move quickly from this phase to the *countdown*.

● In the *countdown* patients are still interested in having their families visit them. However, as they are "talked out," the presence of the family seems sufficient. The nurse should inform families that, as the day of the operation approaches, their presence, rather than verbal discourse, may be what patients need. The nurse must remember that families, too, need her support as the surgery is often frightening for them.

How can the nurse best help families while they support patients? Are families allowed time to talk with the nurse? Do we, as nurses, need to identify more clearly what families do to support patients so that we can assist them?

● The most important statements made by patients in the *countdown* are simply, "I'm all talked out" and "I'm not going to change my mind." The nurse needs to be aware that talking is no longer useful, but her actions are evidence that she can be trusted to be in control of the patient's life.

Conclusion

This study was prompted by the apparent isolation of patients awaiting cardiac surgery, in an attempt to understand more about the limited nurse/patient interaction that characterizes this period. Is this communications breakdown caused by the fact that the nurse does not fully understand the needs and feelings of the patient during this time? If so, reading about the concerns expressed by the patients in this study as represented by Mr. Linder may offer some enlightenment.

The data suggest that the feelings of cardiac surgery candidates are worked through chiefly on a verbal level and that these patients therefore urgently need psychological support. Effective nursing care demands recognition of this requirement as well as attention to the physical needs of patients waiting for cardiac surgery.

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An Affair of the HEART

John Duffie

Like most people, I always thought a heart attack was something that only happened to somebody else, like a car accident. Then I had one of my own, 3,000 miles from home on the third day of what was to be a three-week holiday. The doctor called it a myocardial infarction, a term which appealed to me because it seemed to add a little class to the whole affair.

The event had many bad effects. It kept me in hospital for six weeks, creating a lot of work and nuisance for some exceptionally nice people. It ruined my holiday, scared the stuffing out of me, and brought a great deal of worry to my wife and family. On the other hand, there were benefits. It forced me to take a long rest, something I should have had sense enough to do of my own accord. And of course my heart attack has given me an entirely new subject for boring my friends, acquaintances, and even casual passersby.

Much of the initial attack is hazy in my memory. I can remember a terrible crushing feeling, as though a pro linebacker were kneeling on my chest and a severe pain, incredibly like a toothache, in both jaws. I say 'incredibly' because I have reached the stage where, if my teeth ache, I drop them in a glass of water and tell them to go ahead and ache.

I also recall the ambulance ride — feeling that I was taking part in a rerun of *Emergency* on TV. I was disappointed that the attendants didn't call Ramparts and give my vital signs to Bobby Troup, but was sustained through the ride by the thought that I would wake up to find that delicious morsel, Julie London, hovering over me as she soothed my fevered brow. The bearded intern who met me at the hospital was quite a let-down.

The next morning I woke up to find six electrodes glued to my chest, all feeding into a little TV set over my head. There were also two intravenous needles stuck in my arm, their tubes leading to two bottles of clear liquid hanging from what looked like a small hangman's scaffold. I remember asking a nurse if she could fill one bottle with gin and the other with vermouth, but she paid no attention other than to remark that they didn't have any olives. All the electronic gear brought a feeling of déja vu. Then I realized that my TV conditioning had again betrayed me — in my imagination I saw myself as none other than the six million dollar man, give or take a dollar or two.

The electronic monitoring system caused one minor crisis. I woke up one morning to find that in thrashing about in the night I had pulled three of the wires out of the tiny six-holed plug that fed proof of my existence to the oscilloscope. Without giving the matter too much thought, I plugged the wires into the first three sockets that I happened to see. The resulting pattern on the screen brought the staff on the run, all certain that I was not only dead, but had risen.

A good mental attitude is important in heart therapy. I was lucky because I was looked after by people who were not only capable and efficient, but were blessed with enough sense of humor to bring a few laughs into an otherwise grim situation. For example, there was an occasion when a pleasant young nurse was trying to insert an IV needle in my arm. Unfortunately I am cursed with small, elusive veins — a technician once told me they were known as "rollers" in the trade — and my nurse was jabbing away, like a housewife with a broomstraw testing a cake for 'doneness'. After a little of this I asked, "What's going on? Are you playing 'pin the tail on the idiot' or something?" She looked at me scornfully and replied, "Don't snarl at me. You're the one with the substandard veins."

One night the same nurse asked me if I would like some orange juice — when I accepted she ran into trouble finding a way to open the can. I heard her mutter to a colleague, "With the price of scalpels being what it is, all the can openers are down in surgery."

Adding to the carnival air of the place was the jolly lab technician who appeared every day to collect blood samples, announcing her arrival with the cry of "The vampire strikes again!"

I have many more pleasant memories. Heart patients work their way through a number of levels of activity, and I had reached the point where I was required to walk up and down a short flight of stairs three times a day. One night I dozed off about 9.30, about a half hour before official 'lights out', only to be shaken awake at 9.40 to take my sleeping pill. (I know this is a cliché but, so help me, it happened). I had barely dropped off to sleep again when another cheerful soul woke me up a second time, suggesting that it would be a good opportunity to do my stair climbing.

I am not foolish enough to claim that a heart attack is a good thing. But if you manage to survive, it can have the beneficial effect of scaring you into living a slower, less frantic and more sensibly-paced way of life. Years ago, in Toronto, I saw graffiti which read, "Death is nature's way of telling us to slow down." A heart attack, while less drastic, can deliver the same valuable advice.

John Duffie (Victoria, B.C.) is a member of the American Association of Retired Persons, the National Council on Aging, International Federation on Aging, the B.C. Old Age Pensioners, the Canadian Authors' Association, and numerous other groups. Retired from his position of Property Tax Manager with Canadian Pacific, Duffie has channelled his energies into other areas: "Believing strongly in varied interests for retired persons, I am trying to develop a sort of second career as a free-lance writer, specializing in the field of aging and retirement." His work has appeared in several weekly papers in the Victoria area, and he has had some speaking engagements and a couple of T.V. appearances, all concerned with problems of the elderly.



Self-concept of the myocardial infarction patient

The treatment of myocardial infarction patients has changed substantially in the past decade but, for many patients, a heart attack still spells the end of a normal, productive life. Nurses can do a great deal to combat this attitude and help patients maintain a positive self-concept. Successful nursing intervention starts at the time of admission and continues until the patient is ready to resume his normal living patterns at home.

Carroll Iwasiw Cook

Patient study

Ten years ago, at the age of fifty-nine, Mrs. Adams first experienced chest pain. Her doctor advised her to "take it easy" and Mrs. Adams promptly retired from her job. With each succeeding episode of chest pain, Mrs. Adams curtailed her activities more and more. She now only washes her dishes and makes her beds "if I feel like it." Because she is afraid that "something might happen," Mrs. Adams never goes for a walk. She has confined herself to her home, spending her time reading and watching television.

Mrs. Adams feels that she had not been healthy "since my heart started up." She believes that her health is deteriorating daily, even though there has been no rapid progression in her coronary artery disease.

Mrs. Adams views herself as a chronically sick person, unable to participate in any physical activity. She feels that she must always be careful because any excitement or exertion might "be bad for my heart." Mrs. Adams' view of her heart and of herself have led her to become a cardiac cripple.

The symbolism that surrounds the human heart has a direct bearing on the attitude of the myocardial infarction patient towards the event that results in his admission to hospital. If he is like most of us, he regards the heart as the center of life, the seat of his emotions. A threat to this vital organ constitutes a threat to his personal identity. Within the space of a few short minutes, his attitude towards himself as a living, breathing individual changes drastically. Unless the health professionals caring for him take steps to prevent it, his self-concept is almost certain to suffer permanent damage.

Self-concept is a person's total view of himself and his appraisal of what he sees. It includes his attitudes and beliefs about his abilities, his occupation, his successes and failures, his body shape, his relationships with others, his personal expectations, and his sexuality. A person's self-concept is influenced by the reactions of other people towards him, and by his perception of their behaviors.

The heart attack victim 10 years ago

A decade ago, the treatment of patients with myocardial infarctions was considerably more conservative than today. Members of the family were often told, "It's a miracle he lived through this." Having "lived through it," the heart attack victim was not allowed to do anything for himself.

Bedrest for three to six weeks was common. The nurse fed the patient and did passive range of motion exercises on his limbs for at least two weeks. Progression to a bedside chair meant being lifted into it from the bed. Walking was introduced into the rehabilitation program at about eight weeks postmyocardial infarction. Discharge home might have been in an ambulance to minimize exertion during the trip.

Vague discharge orders to "take it easy" and "don't overdo it" offered no guidelines about an acceptable activity level. The patient was often left with the feeling that the quality of his life was severely altered.

It is not surprising that many myocardial infarction patients developed an image of their hearts as fragile organs. Fear of sudden death was common among these patients. If health personnel in the hospital were afraid to let them be active, then surely something terrible would happen if they resumed their usual patterns of living.

The heart attack victim today

Times have changed and now it is recognized that most myocardial infarction patients are physically capable of returning to their usual activities, or, under medical

supervision, even increasing their physical activity. Active leg exercises and perhaps chair rest are begun in the Coronary Care Unit. Ambulation may begin within two weeks postmyocardial infarction.

Coronary Care Unit

It is in the Coronary Care Unit that the groundwork is laid for the patient and his family to develop a positive attitude towards his illness. Attitudes conveyed to the patient and his family in the CCU are likely to be reinforced by the crisis situation of the patient/family unit.

The nurse's first task is to listen to the feelings expressed by the patient and his family. This will give her insight into how they perceive a myocardial infarction and what changes they expect in their lives.

While the patient is in the Coronary Care Unit, the nurse can allow him some independence. Choices are possible within the routines of daily care. For example, the patient can choose to have his bath before or after breakfast.

The coronary care nurse is in a unique position to prevent overprotection of the patient by his family. By outlining future activity steps, she can demonstrate her belief that the patient will not always experience pain and fatigue. If she takes the time to describe the progression in activity he will experience after transfer from the Coronary Care Unit, the nurse can offset the feelings of dependency the patient is experiencing.

While he is still in the Coronary Care Unit, the nurse can help the patient maintain his concept of himself as an independent, responsible adult. She can emphasize to the patient that he has some control over what happens to him. She can help him become sensitive to his bodily sensations — the location, character and intensity of his pain. She can also help him begin resuming responsibility for his body and health by letting him participate in the decision to try nitroglycerine and oxygen or an analgesic injection to alleviate the pain.

One of the most important ways in which the nurse can help the myocardial infarction patient maintain his self-concept is to emphasize his areas of competency. This can be done only when the nurse knows her patient and which aspects of his life are important to him.

The Ward

Nursing intervention designed to help the patient maintain his self-concept is continued on the ward. Here the medical goal is for the patient to reach the level of self-care required when he goes home. The nursing goal is to help the patient and his family continue to develop a healthy attitude towards himself and his illness.

During his program of gradually increased activity, the nurse conveys an attitude of confidence in the patient's ability. Her relaxed attitude as the patient assumes more responsibility for his self-care, does much to dispel the fears of sudden death associated with activity. If she includes the family in the activity program this will help to alleviate their apprehension and to promote family interaction. It is important that activity be alternated with periods of rest to prevent undue fatigue and feelings of helplessness.



Emphasis on signs of improvement help the patient to see himself as progressing towards health. It will engender in both patient and family an expectation that usual life patterns may again be possible.

Planning for discharge

Successful readjustment to life at home after his hospital stay requires careful planning on the part of the health care team, the patient and his family. Areas that should be reviewed together before discharge include:

— a warning that a feeling of fatigue once he gets home is normal and is due partly to attempts to resume more activities and partly to deconditioning in hospital. Knowing that this "weakness" is normal and temporary can prevent feelings of depression and hopelessness.

— concrete information about medications (name, dosage, desired effects and possible side effects) as well as information about what to do if chest pain recurs. These add to the patient's feeling of competence and control and help to bolster his self-concept.

—desirable modification of smoking and eating habits and information on the amount and type of permitted exercise, sexual activity, the need for follow-up visits to a physician, and the ability to resume normal working habits.

A definite plan of activity and continuing support from the health team can go a long way towards preventing disruptive family arguments that assault the self-concept. It can also reinforce the steps already taken in hospital to ensure that the myocardial infarction patient does not become a cardiac cripple.

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The Transfer Process

Betty Lethbridge, Orranun Somboon, Hattie Lee Shea

The crisis that precipitates admission of the MI patient to the Intensive Care Unit and the stress that these patients experience in this hospital setting has been well documented. What is less generally recognized is the extent of the psychological adjustment involved in the subsequent transfer of these patients from the ICU to a general medical ward.

The authors set out to learn more about the transfer process and its implications for nursing care. Their subjects were 26 cardiac patients who were observed during their stay in ICU and for a period of 24 to 72 hours on the wards after the transfer took place.

When the critical phase of the MI patient's recovery is over and he no longer needs the intensive care provided within the ICU, he is transferred to a general medical ward. This transfer involves transition from a state of total dependence to a state of relative independence. The patient leaves an open setting in which there was a high nurse-patient ratio, constant presence of the nurse, and where his heart activity was carefully monitored. He moves to a medical ward where there are fewer nurses not always in sight and where assessment is made by the patient's symptoms, placing greater responsibility on the patient. The nurse-patient relationship that fosters dependence within the ICU ends abruptly and the patient must adjust to a change in doctors, nurses and physical environment. As a result, transfer causes a break in the continuity of care and frequent inconsistencies of care. Patients are likely to experience a sense of loss, abandonment, fear and insecurity that one investigator has described as "separation syndrome."

Because of the particular psychological problems of cardiac patients in the ICU and the added stress of the transfer process, it was anticipated that patients would experience anxiety and physiological complications following transfer. The staff of the hospital where the study was conducted confirmed this observation. The Head Nurse on a medical ward that received many of the patients from ICU stated that problems such as chest pain, anxiety, fear, insomnia, and demanding behavior frequently occurred within 72 hours of transfer. She suggested that the time of transfer might also contribute to patients' problems of adjustment and pointed out that patients are usually moved to the ward early in the afternoon when beds become available. This is a very busy time of day for the nurses who are completing their day's assignment and preparing reports for change of shift. As a result, the number of nurse-patient contacts are reduced, especially in comparison to the ICU.

In order to carry out the study, the authors interviewed patients directly and also studied current and past patient records. Information was collected on: mode of admission, diagnosis, time of transfer, expressed feelings and complaints, behaviors exhibited, medical (doctor's orders for recheck EKG and CPK) and nursing intervention within 24-72 hours of transfer.

Admission by Emergency

Twenty-five of the 26 patients studied were admitted to ICU from the Emergency Department. One author has observed that this involves a psychological as well as physiological crisis. The patient has no alternative but admission and complete dependence on others, and there is no time for preparation. The patient within ICU has no control over what is happening to him. He feels helpless and tends to overevaluate the power of the helping staff. As a result, he becomes increasingly dependent upon the doctors and nurses and the complicated equipment to which he is attached.

Transfer

The patients stayed an average of five days in the ICU, and then they were transferred to a general medical ward. Sometimes they were moved rather abruptly when a bed in the ICU was needed for a new patient. Patients were disconnected from the monitor just prior to transfer. Immediately following transfer, new interns and nurses were assigned to the patient.

Within 72 hours of transfer, close to half of these patients (42 percent) voiced specific physical complaints such as chest pain, headache and dizziness. Eight of these eleven complained of chest pain. In four cases, the physician responded by ordering an EKG and CPK. Three of the four test results showed no evidence of further pathological change. The pain and discomfort suffered by these

patients was thought to be related to anxiety following transfer.

Mr. G., a 47-year-old married man, was admitted to ICU from Emergency with severe chest pain. He was diagnosed as having an acute myocardial infarction. His physical condition stabilized within four days and he was transferred at 1700 hours to a medical ward. Shortly after transfer, Mr. G. complained of chest pain and nitroglycerin 0.6 mg was administered which brought relief. On the second and third days following transfer, Mr. G. continued to complain of chest pain. An EKG and CPK were ordered to investigate the possibility of an extension of his M.I. The results indicated no further pathological change. Through interviews it was learned that Mr. G. was worried because his condition required restricted activity and he expressed considerable anxiety about the possibility of these limitations being permanent.

Fourteen of the 26 patients studied exhibited behaviors indicative of anxiety such as restlessness, tearfulness, insomnia, poor appetite, refusing care and/or demanding attention.

Mrs. S., a forty-two-year-old married woman, was admitted from the Emergency Department with an acute M.I. Six days later, she was transferred rather abruptly during the evening because a bed was needed in ICU. The first night on the ward she complained of chest pain and insomnia. The next day she became very upset, refused care and was perceived by the staff as being an uncooperative patient. However, during an interview with Mrs. S., she expressed considerable anxiety related to her condition. She was afraid of dying suddenly, as had several of her family members in the recent past.

Time of Transfer

Twelve of the 26 patients were transferred in the afternoon and evening (1300-2400 hours). Of these patients, 10 (83 percent) complained of chest pain or exhibited behaviors indicative of anxiety. Ten of the patients studied were transferred in the morning (0700-1300 hours). Of these, less than half, (40 percent) complained of pain or exhibited behaviors indicative of anxiety. (Time of transfer was not available in four cases).

These results would seem to indicate that transfer during the afternoon is more frequently associated with the development of patient problems in adjustment than transfer during the morning. One seemingly important difference between morning and afternoon transfers is the number of nurse-patient contacts. Reduction of nurse-patient contacts is to be expected following transfer because of the change in physical environment: the patient moves from the open area of ICU to a room on the ward. However, contacts are further reduced in the afternoon because of the preparation of reports for change of shifts and because the actual number of nursing staff is reduced in the evening.

Nursing Implications

How a person responds at a given time will depend upon how he perceives the situation. If it is perceived as threatening to his identity, sense of being or personal security, he responds with anxiety.

Although the patient may understand that his transfer is a sign of improvement and an indication that the critical phase of recovery is over, emotionally he may not be ready for the move. Many demands are placed on the patient at this time. He must adjust to a new environment, new staff, less intensive care and become more independent when emotionally he may be very concerned about what a heart attack may mean to his survival and future lifestyle. Thus, it is not surprising that the patient's anxiety increases at this time and if left unresolved, can interfere with his recovery.

If the nurse is to be effective in meeting the patient's needs, she must be aware of how the patient is perceiving his condition and how he interprets what is happening around him. The patient will respond to his own perception of a situation, not the overt reality of it. The nurse must seek to understand the meaning of the patient's feelings and behavior from his point of view and then validate her interpretation of his needs by talking with him. Only then can appropriate nursing intervention and planning of care take place.

Understanding what is happening between herself and the patient is central to nursing practice and comprises the basic framework for the help she gives. For example, a few days following transfer from the ICU, Mr. K., a post-M.I. patient, asked the nurse for information about heart attacks. Because he did not appear to be anxious, the nurse assumed Mr. K. was not anxious and was only asking for information. Responding literally to his request, she gave him booklets to read. The following day, Mr. K. became extremely anxious about his condition and had to be calmed with tranquilizers administered intramuscularly. Had the nurse talked with Mr. K. to find out how he felt about heart attacks and any concerns he might have had, the anxiety attack which occurred might have been averted.

In conclusion, with a change of staff and a reduction in the number of nurse-patient contacts in the new environment of the medical ward, the post transfer period is indeed a vulnerable time for the patient. Knowing this, the nurse can predict that the patient will feel anxious following transfer even though he may not give overt indications of this concern and she can then give him the extra support he needs. The establishment of a helping nurse-patient relationship requires collaboration of nursing staff from both the ICU and the medical ward. Working together, they can do a great deal to counteract the stress felt by the patient in his new environment.

Authors Orranun Somboon and Betty Lethbridge were fellow students in the Master's program of the School of Nursing at Dalhousie University when they wrote this paper. Their professor in Medical-Surgical Nursing was Hattie Lee Shea who is a graduate of Methodist Hospital in Dallas, Texas and obtained her BSN Ed. and MSN from the University of Texas.

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Plan of care: the young child on dialysis

Until recently, children with kidney disease who were under five years old were not routinely accepted into a dialysis - transplantation program. The multidisciplinary approach now used by the staff of the dialysis unit, Hospital for Sick Children, demonstrates that very young children can be maintained on dialysis until successful renal transplantation is achieved.

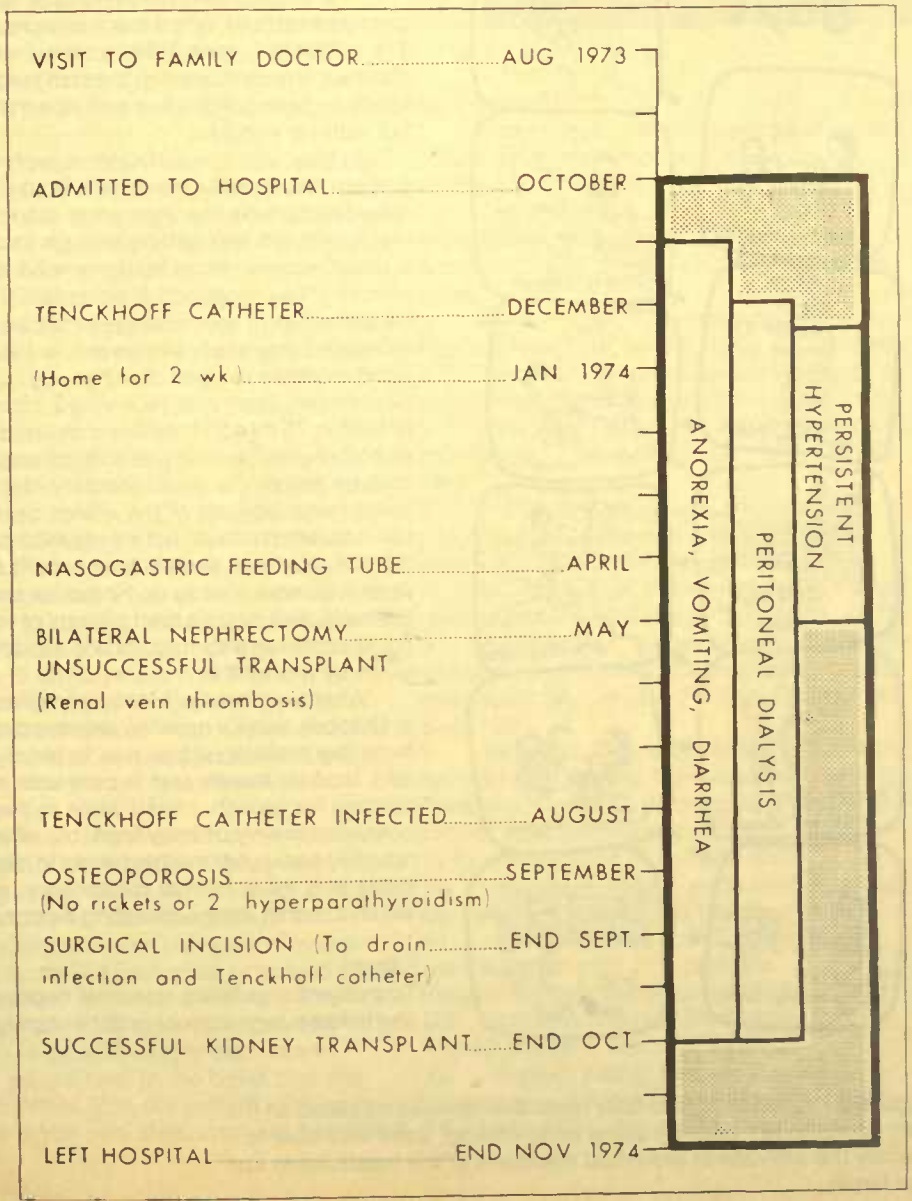
M.A. Irwin, J. Young, D. Matthews, L. Christensen

The number of children with kidney disease being accepted into the dialysis-transplantation program at the Hospital for Sick Children, Toronto is growing larger each year. In its annual summary for 1975, HSC's dialysis unit reported that from 1967 to December, 1975, a total of 63 children entered the program; a total of 71 transplants were performed over seven years. As of December 31, 1975, there were still nine children waiting for transplants.

Technically, no child is too young for dialysis and transplantation. However, the physical, psychological and social stresses these procedures placed on the very young child and his family led the dialysis-transplantation team to develop a unique plan of care for each child. Members of the planning group included physician, surgeon, dialysis head nurse, ward head nurse, dietician, social worker, recreationist, consulting psychiatrist and the patient's family.

The following case study is an example of how a multidisciplinary approach can foster normal growth and development and help to maintain the quality of life for both child and family.

Figure 1



Jane

Jane Smith had always appeared healthy but was small for her age, weighing only 10 kg at 2 ½ years of age. Because of her poor appetite and failure to gain weight, her parents took her to the family physician in August 1973. Routine diagnostic tests detected protein in the urine and a renal biopsy revealed glomerulonephritis. Two months later, she was admitted to The Hospital for Sick Children, in acute renal failure, with a serum creatinine of 10.2 mg/dl. (Normal value 0.4 - 1.2 mg/dl). Emergency treatment was given in the intensive care unit and Jane was started on peritoneal dialysis.

As shown in Figure 1, Jane's clinical course was stormy. Multiple problems and infections from two to thirteen months after her initial admission necessitated frequent changes in the dialysis regime during her long stay in hospital. Persistent problems included anorexia, vomiting, and diarrhea. After a brief stay at home, readmission was necessary because of high fever, dyspnea, mild

pulmonary edema, and right lower lobe pneumonia.

Patient-care plan

The dialysis-transplant team formulated a patient-care plan, assigning specific roles to key disciplines. Nursing carried the responsibility for day-to-day continuous direct care. One nurse in the dialysis unit and one on the ward coordinated the plan. They implemented new approaches as problems were identified, and advised other team members of changes in plans and management suggestions. Approaches which proved successful were identified and a daily routine was designed for Jane. *(Figure 2)* The team members met regularly for conferences, including one or both parents if possible, to discuss current difficulties and make plans for the coming weeks.

During the formulation of the patient-care plan, Jane's physical as well as psychological needs were discussed. The need for mothering and for consistent management was recognized from the outset as being of primary importance in Jane's care. Her age and stage of development were also kept in mind, particularly as she tended to regress when very ill and under stress.

Initially, Jane's care was extremely difficult for the staff and for her family. Everyone experienced frustration and despair at some time. Gradually, however, with Jane's acceptance of the dialysis regime and hospitalization, and with consistent care, she began to respond to the staff. Her behavior changed: a sense of humor and a distinct, endearing personality emerged.

In addition to the many medical problems, the patient-care plan focused on three major issues:

- maintaining a normal level of development,
- providing adequate nutrition, and
- offsetting maternal deprivation while maintaining family stability.

Development

The recreationist, trained in behavior patterns and developmental needs, set the pace and goals for the nursing staff in play discipline and in general interaction with Jane. Every day, a certain time was set aside for Jane to play with the recreationist.

During the first six months, Jane showed many signs of emotional disturbance: she twirled her hair continually, was withdrawn, rocked constantly in a rocking chair, and clung desperately to anyone who picked her up. Jane's concentration span was very limited — most of her brief play periods ended in frustration with Jane throwing her toys on the floor. Gradually her concentration span increased and she began to respond. Planned activities included: play with toys such as blocks, puzzles and articles that she would be exposed to in hospital e.g. tubing, syringes, and tapes; creative play; and physical activity in the outdoor playground with her parents and staff. When the recreationist was not available, the ward and dialysis unit nurses applied the same approaches, using the patient-care plan as a guide.

Creative play proved to be Jane's favorite activity, especially painting and molding play-dough — activities that retained their popularity after she returned home. The recreationist developed Jane's play skills to the point that her response to play became an accurate indicator of her well-being; furthermore, the daily play routine helped to stabilize her attention span, which tended to fluctuate with her health.

Nutrition

Jane was a very poor eater. Her mother and the dietician tried many ways of preparing foods and varying menus, but Jane did not eat enough to meet her nutritional needs. Mealtimes became a battleground. She would break up her food into tiny morsels and pick at her meal for hours.

Five months after admission it was decided that one person (the recreationist) should deal with mealtime and that no other staff should interfere. This approach, which was continued for one week, proved unsuccessful. Other approaches were tried such as quiet play before meals and sitting Jane at the table with her parent(s) and brother but nothing improved her eating habits. To offset her nutritional imbalance, the nurses frequently offered her drinks of high caloric content. Fortunately, she was always thirsty and so received some of her nutritional requirements from them.

In April 1974, six months after her admission, the team reassessed the dialysis regime and tried to replan Jane's diet. However, even with the new regime, she was still unable to keep her food down. Consequently, a nasogastric feeding tube was inserted.

The feed concentration was started at 3/4 calorie/ml of fluid. When this was increased by 1/4 calorie/ml, Jane either vomited or had diarrhea. For three weeks, the staff tried giving feeds — both continuous and intermittent — but with no success.

In May, Jane had a bilateral nephrectomy and an unsuccessful transplant. Post-surgery, nasogastric tube feedings were resumed. A major problem was getting enough calories in a small volume, since fluid overload was a concern. To compound the problem, the caloric value of the feedings could be increased only every two weeks, since a more rapid increase caused diarrhea. By September, Jane was receiving 2 calories/ml of feed in 75 ml q3h together with 'treats' such as soft cheese, biscuits, and 30 ml aliquots of cola by mouth. To avoid the very high phosphorus content of the cream-based formula, which could not be cleared by dialysis, soybean protein was substituted. Jane was now able to go home for short intervals, and despite brief periods of vomiting could continue with nasogastric feedings given by her mother.

After a successful kidney transplantation in October, Jane's appetite improved rapidly. Now, the main objective was to teach her to take food by mouth and to consume enough calories for growth. Intake while in hospital consisted mainly of baby food, but after Jane returned home, her mother began to introduce foods of a more normal consistency, and within a month Jane was eating a normal diet.

Family

To prevent significant maternal deprivation and to keep Jane in touch with her family, Mrs.

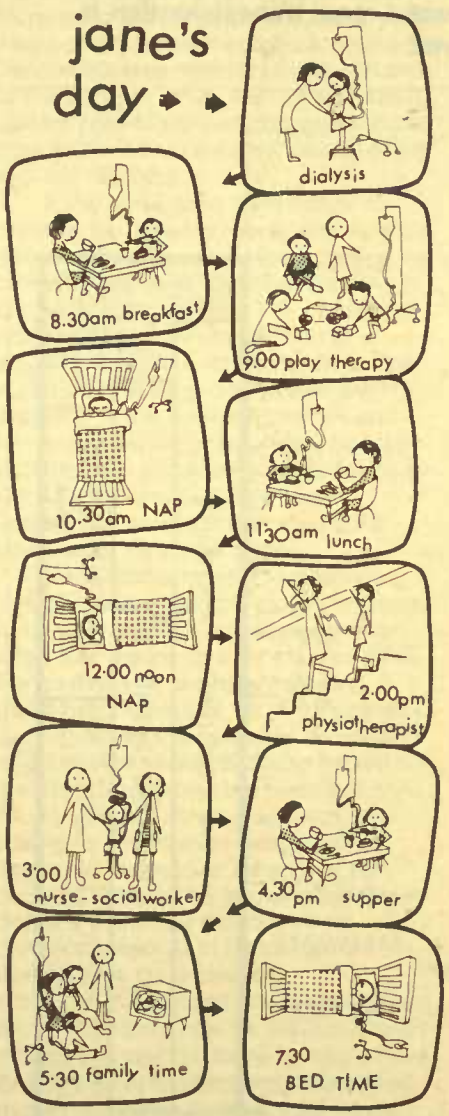


Figure 2 - Chart of Jane's daily routine which was mounted on the wall opposite her bed. By using color-coding, Jane was able to identify the activites of individual members of the health team and her family.

mith was encouraged to spend two days a eek with Jane during dialysis while her father nd brother spent time with her on weekends. r. Smith had to rearrange his work shifts to ive his wife to and from the hospital which as 60 miles from their home. Jane's n-year-old brother was forced to become ore independent and self-reliant. The Smiths eeded help to maintain their functional nd emotional stability during Jane's long ness. The social worker was primarily sponsible for family counseling with the help the staff psychiatrist.

On first learning about Jane's diagnosis, er family was shocked and grieved. Mrs. mith became silent, almost immobile while r. Smith was more verbal, expressing his nxiety through criticism and a frantic search r alternatives. Gradually with further scussion, they were able to explore their elings and bring them into perspective. The hysician and social worker talked with the arents about the decisions they would have make. The realities of suffering, growth fficulties, transplant failure and numerous perative procedures, maternal deprivation nd overall effects on the family were easoned through carefully for several weeks. he outcome was a decision that Jane ntinue dialysis and await a transplant. (In ctober 1974, Jane did undergo a successful ansplant operation).

During the thirteen months that Jane was the dialysis-transplantation program, there ere many emotional "ups and downs" for her mily. There were many frustrations, changes nd disappointments for them to cope with. owever, the Smiths responded well to pportive counseling and they participated s members of the team in helping to plan ane's care.

Conclusion

The example of this young family was a evelation to the team. Jane would not have een able to surmount the physical or motional difficulties if her family had not nared in the responsibility for her care.

Now, two and a half years since her first dmission to hospital, Jane's vocabulary and lay habits are normal for her age although iscipline is still a problem at times. She is ating normally and is consuming sufficient rotein and calories for her nutritional needs nd growth. Now, with a successful kidney ansplant, her serum creatinine is within ormal limits.

As a result of this experience with Jane nd her family, children under five years of age re being more readily accepted into the ialysis-transplantation program at this ospital. Children over one year of age are ow maintained on peritoneal or hemodialysis ntil the time of successful kidney transplant. he team continues to use the planned pproach to care, involving each team ember as outlined, in the belief that this pproach offers both the patient and team embers some very demonstrable benefits.

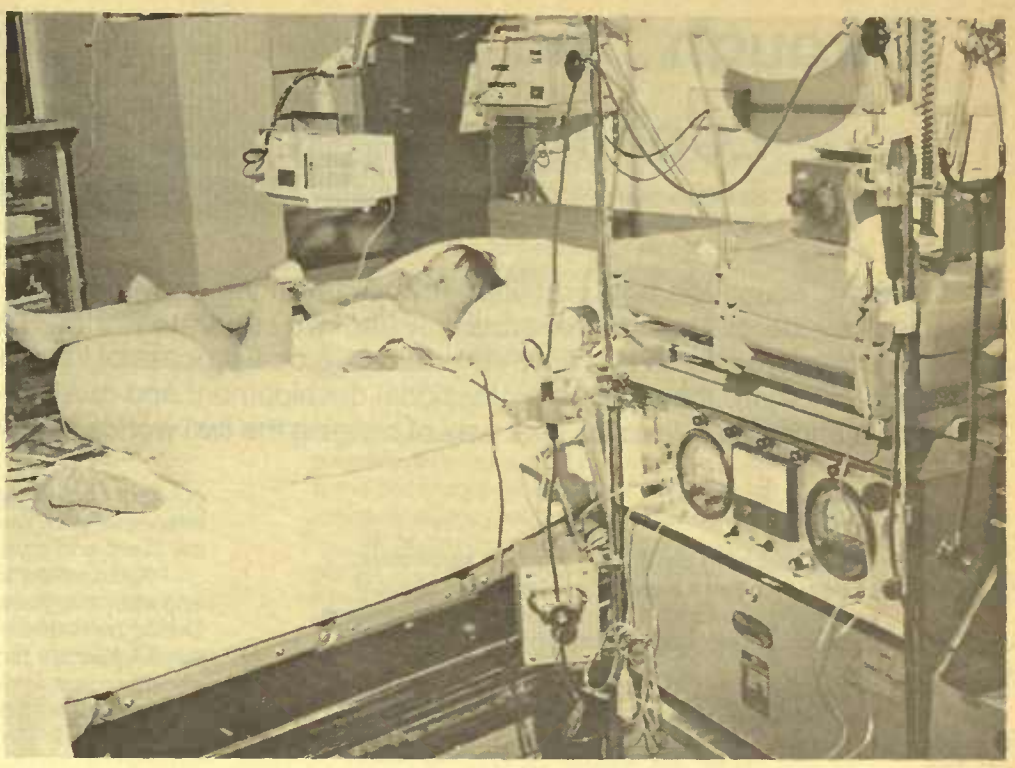


Photo: Office du film du Quebec

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M.A. Irwin (above) R.N., R.M.N., B.Sc.N., C.P. is head nurse of the dialysis unit; J. Young, R.N., B.Sc.N., is a ward head nurse; D. Matthews, M.S.W. is a social worker; and L. Christensen, Dip. E.C.S. (Recreationist) are all members of the dialysis-transplant team at The Hospital for Sick Children, Toronto.

The authors extend their thanks to Dr. G. Arbus, Director and Dr. R.D. Jeffs, Surgeon of the dialysis-transplant program.

Through the Looking

Gail Gitterman
Paula Goering

Nursing education and practice tend to run along parallel paths, functioning side by side, but split rather arbitrarily into two separate worlds. These 'worlds' have much to offer to one another in the reciprocal process of learning-teaching, and both share the goals of professional development and quality patient care. The authors here describe their way of bringing the two worlds into closer touch.

Gail

After teaching psychiatry for two semesters. I decided that I needed professional clinical upgrading, and with a fury stemming from some unmet driving need, I attempted to get it ...

I was pretty uneasy at getting involved again in the clinical setting. Heading for a third semester as a teacher in psychiatric nursing, I hadn't been actively involved in a nurse-psychiatric client relationship since my student days. When I began teaching, I had naively hoped that expertise in the clinical setting would gradually come upon me, but after two teaching semesters, I decided that I needed to take more immediate steps to upgrade my clinical skills. My goals were to increase my skills in a one-to-one relationship, to improve my first-hand knowledge of community resources, and to use my experience for a future learning-teaching tool. I hoped to gain from my experience both as a therapist and as a teacher.

Initially, I faced some practical problems associated with trying to include some clinical practice during the teaching year. Lack of available time was one problem I had to deal with. At Ryerson Polytechnical Institute a unique opportunity presented itself during a non-teaching semester, a time for planning courses and curriculum, and for taking a vacation. A second problem lay in finding a clinical agency where I might gain my experience. At Ryerson, we affiliate with Queen Street Mental Health Centre, a large public psychiatric centre, and it was to this agency that I turned.My request for an opportunity to be involved in clinical practice was accepted readily by the director of nurses there.

My greatest concern was with where to find supervision. There were two likely alternatives: I could meet with one of my colleagues weekly to discuss the development of my relationship with my client through the use of the process recordings I kept; or I could utilize the resources of the clinical agency. Paula Goering, the clinical specialist at Queen Street Mental Health Centre was willing to supervise my learning experience. After some discussion, I decided to work with Paula.

Together, Paula and I decided on the form that her supervision would take. I was to meet with a client twice a week: I would record one of my meetings using a process recording; during the other meeting, Paula would watch me and my client through a two-way mirror throughout the length of our interview. Paula and I arranged to discuss these interviews once weekly following a meeting between my client and myself.

Paula talked to a doctor involved in after care, and then suggested an appropriate client for me. During our initial interview, the client and I established the terms of our relationship. We decided to meet twice weekly for eleven weeks. Personally, I felt that this would be a minimum length





of time necessary for therapy. I realized that the duration of therapy actually depended on many things — the time available, the intensity of the relationship, and the freguency of meetings during the week.

The client, Emily, had been hospitalized for three months, and during this period of time, had experienced hallucinations. A recent immigrant from the Phillipines, she found herself lost and lonely in Toronto. Before she was hospitalized, she had met and married a Canadian. When I first met Emily, she was living at home with her husband, and visiting after care for Moditen injections every two weeks.

The problems that I encountered in my meetings with Emily helped me to appreciate first-hand the problems my students faced. They also demanded that I become personally involved as a therapist. At first, I had a lot of trouble being spontaneous and natural in my meetings with Emily. I was very anxious that every part of communication be skillful and therapeutic. All those readings seemed to be a barrier to effective interaction. It wasn't until much later in our relationship that my self-conscious concern left me and I could let myself feel and use the warmth I felt for Emily.

Emily presented many problems of a sexual nature and this tended to further hamper my spontaneity. I turned to Paula for additional help and together we reviewed current literature on sexual therapy.

I met with further difficulty in the termination stage of my relationship with Emily. I found it helpful once again to turn to nursing literature to steer me in the right direction. I knew what I had to do, but had some self-doubts about my ability to carry this part of the plan through. For me, termination was stressful, and provoked a range of feelings. I worried about meeting the goals of therapy, feeling a need to tidy things up and leave no threads dangling. I felt sad because Emily and I would not be sharing this time anymore and was troubled by guilt when I realized how much more there was to be accomplished. I was also afraid that Emily would regress, that hallucinatory symptoms would reappear. There was a need in me to feel needed and indispensable and I hoped that Emily shared some of these same feelings. I encouraged Emily to share with me her feelings about our relationship and its termination. She commented on her sadness, but was not able to express anything more.

The question remains, what did I do for Emily? She had married during an acute psychotic episode. Communication between Emily and her husband had been poor, and continued to be so. It seemed that she was unable to express her needs to her husband. I tried to help Emily direct her energy toward a healthier relationship with her husband by exploring these needs and discussing problems with her, so that she, in turn, could talk to her husband about them. I listened and was supportive to Emily. When a problem concerning birth control came to light, I provided some health teaching regarding normal menstrual cycles, fertility times and contraceptive measures. Her need for some activity in the community was met by introducing her to a volunteer agency within which she could participate.

What did I gain from this experience? As a nurse whose skills in this area were minimal, I feel there was some growth. Paula was able to help me understand my feelings and the way in which they guided me throughout the interactions. Because of Paula's skillful and warm responses, I was able to use our relationship as a role model for my relationship with Emily.

Educationally, the experience has proven worthwhile. My relationship with Paula has given me a greater appreciation of the effects of empathetic supervision on the student. I hope that our relationship will serve as a good role model for my interactions with students and that by confronting Emily's problems I can better understand what my students face.

My experience has led a colleague and me to begin a new teaching project which is proving to be an excellent teaching aid in the classroom. The two of us have made a videotape depicting a dialogue between client and nurse — with my colleague playing the nurse, and myself, the client. The result was a one-hour tape in three sections: the first depicts the initial interview between nurse and client; the second segment demonstrates the nurse's response to the client's need for health teaching (therefore dealing with the "content" of the interview); the third part depicts the "process" of the interview by showing the nurse as she deals with her client's silence. This tape will be utilized in both undergraduate and postgraduate courses at Ryerson. It will be a library holding, ready to be used in a multidisciplinary approach to learning.

Role playing has become an effective evaluation tool for me. From observing my colleague's skillful responses during the interviews I have learned a great deal more about effective communication and am able to understand more of the process of the interview.

I feel very strongly that an experience that gives the teacher an opportunity to improve clinical skills is a vital and necessary part of a teacher's yearly responsibilities. It can be carried out at times of the year during which the teaching load is less demanding. Ideally, if there is a firm commitment from all faculty members to this principle, teaching loads could allow for the incorporation of a learning experience for teachers.

The task of updating clinical skills can be applied

to any area of nursing. Within the medical-surgical area, supervision could be available through the nurse clinician, clinical specialist and/or head nurse. Together with the teacher, they could help to evolve in-depth nursing care plans. This may have far-reaching implications as the teacher attempts to consolidate for his/herself new scientific knowledge of disease, therapeutics and nursing and technical expertise. The teacher will have to tap many resources. Planning and carrying out nursing care has become increasingly sophisticated, a fact which necessitates precise learning-teaching skills to be developed. In order to be effective teachers, we must also be willing to take the time to learn.

Paula

I was pleased when Gail asked me if I'd help her improve her clinical skills by supervising her in a one-to-one relationship with a client. As a clinical specialist I believe strongly in a close connection between clinical practice and teaching. This seemed to be a good opportunity for a practitioner and an instructor to work together in a mutually beneficial way...

Because I am an active member in a treatment team, it wasn't difficult to make the necessary administrative arrangements to find an appropriate client with whom Gail could work. There is certainly no lack of after care clients who could benefit from a more individualized and intensive approach than what is routinely available. Clients who have been discharged from inpatient treatment frequently receive follow-up care for the administration and supervision of drug therapy. Unfortunately, the important psychosocial needs of the client may not be met because of a scarcity of staff.

Gail's familiarity with the process of supervision from her work with students made it easier for us to set the ground rules. I found her enthusiasm and high level of motivation refreshing and stimulating. Although I am involved in teaching of various kinds in inservice settings, I found it quite different to be working with someone who has the time and energy to invest a great deal in a learning situation.

It was also clear from the beginning that Gail brought with her from the educational setting a wealth of theoretical knowledge about counseling and psychotherapy. I expected that this would enhance her ability to describe and understand her interactions with the client — which it did. Supervision of less experienced and knowledgeable students is often in large part a matter of helping them learn "how to learn" about helping relationships. The ability to observe and analyze behavior is one that is learned by experience. As an instructor, Gail came to the supervisory situation with an intellectual and emotional preparedness to look at what was happening verbally and non-verbally between herself and the client. This made it easier for me to give feedback in a direct and open way.

I was surprised to find that the same knowledge that was an advantage in the supervisory relationship initially interfered with Gail's ability to interact in a spontaneous and natural way with Emily. The first time I observed Gail with the client, I felt as if she were a stranger on the other side of the mirror. The bright, warm and interested woman I'd met seemed inhibited, stiff and cool when interviewing Emily — a problem difficult to identify if a supervisor relies only on process recordings or self-reports. When we discussed this it was clear that Gail's behavior was partly due to the anxiety inherent in a new situation. But she was also responding to a great many ideas that she had read about how the therapist should and should not act. It took some encouragement and time for Gail to learn to rely much more on her own human response to guide her behavior. Emphasizing the similarity between therapist/client and student/teacher relationships helped her feel more comfortable.

When Emily began to describe serious sexual problems in her marriage, Gail and I found it helpful to do some reading of the current literature on sexual therapy. This joint reading provided us with needed information to assess Emily's problems and the appropriate interventions. From our readings, we found that sexual therapy is contraindicated for those who are not stabilized after a recent psychotic break. But Emily persistently and with great distress initiated discussions about painful intercourse, inability to reach orgasm and about the ejaculatory incompetence of her husband. Gail arranged for her to have a gynecological examination and no significant abnormalities were found. We discussed the advisability of using behavioral and educational technique to treat the couple together. We decided that Gail would offer the opportunity for the husband to become involved and use Emily's response as an indication of her ability to tolerate this type of intervention. Emily wasn't interested in including her husband in therapy. So Gail taught Emily about sexual response and allowed her to ventilate her feelings in a one-to-one relationship. Gail and I found that dealing with this problem increased our knowledge about sexual difficulties and treatment as well as our ability to discuss the subject more comfortably.

Termination of our supervisory relationship indicated that the significant dynamics of the therapist/client relationship are often paralleled in the therapist/supervisor relationship. When Gail explored her hesitancy to discuss ending therapy with Emily, she expressed some doubts as to whether she had been effective or helpful. I looked at my supervision of Gail with similar concerns. I found myself questioning whether the changes I'd seen in Gail reflected her growth as a therapist or whether I'd merely influenced her to become more like me. Gail and I talked about the anxieties of termination. At our last session, Emily surprised and pleased Gail by giving her a gift in appreciation of the help she'd received. Gail also gave me a gift in thanks. Gail and I shared both the pleasant and the unpleasant feelings associated with ending what has been a meaningful relationship.

One of the results of this type of relationship between nursing educators and practitioners is improved patient care. The provision of high quality direct patient care by instructors such as Gail is an asset to the client and to the service facility plagued by reductions in staff and increasing needs for treatment. The upgrading of an instructor's clinical

skills will also affect the quality of care given by her students.

I felt that the time I had spent supervising Gail was worthwhile in that it was an opportunity for my own growth. The clinical problems Gail encountered were a stimulus for me to explore and gain experience with the indications and contraindications for sex therapy, something I'd known little about. The process of helping a nursing instructor learn clinical skills widened and improved my supervisory skills. Increased self-awareness about interpersonal behavior and communication was a benefit of both the therapeutic and learning relationships.

Ideally, nursing education and practice should not be split into such separate worlds. Cross-appointments between clinical and educational facilities would allow more instructors to be practitioners and vice-versa. Until such positions are available, alternative ways must be found of bringing nursing education and practice into closer relationship with each other. The learning arrangement we have described is one such alternative. We hope that others will try it.

Gail Gitterman (B.A., University of Western Ontario, London, Ontario; R.N., Nightingale School of Nursing, Toronto, Ontario) worked as a general duty nurse at the Jewish General Hospital in Montreal for 2 years, and taught for 4 years at the Atkinson School of Nursing, Toronto Western Hospital. Presently she is an instructor in the Nursing Department of Ryerson Polytechnical Institute in Toronto.

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Books

Nurses Guide to Cardiac Monitoring Second Edition by P.J.B. Hubner. 66 pages. London, England, Bailliere Tindall 1975.
Reviewed by A. Norah O'Leary, RN, MScN Assistant Professor, Lakehead University, Thunder Bay, Ontario.

This volume has been derived from lectures on cardiac arrythmias presented to the nurses of the coronary care and surgical intensive care units at the Royal Postgraduate Medical School, Hammersmith Hospital. The author's objective is to prepare the nurse to recognize common arrythmias as displayed on a cardiac monitor.

Chapter I simplistically describes a bedside monitor. The statement — "These pieces of equipment [the cardiac monitor] are like small television sets on which the heart beat trace is displayed" — is indicative of the level at which this chapter, and indeed the entire volume, is written.

The second chapter discusses electrodes and their placement. No particular pattern is recommended; indeed the position is not considered important. No mention is made of avoiding areas of muscle to reduce interference.

After a short review of normal anatomy, physiology, and the normal E.C.G., a systematic method for observing monitor patterns is described. There appears to be no provision for obtaining a rhythm strip. The nurse is expected to evaluate the length of the P-R interval by observation of the oscilloscope, and no information is given about normal time intervals during the cardiac cycle.

The following three chapters are concerned with common arrythmias. Sinus bradycardia, sinus tachycardia, extra systoles (atrial and ventricular), coupling (bigemeny), atrial and ventricular tachycardia, atrial flutter, atrial fibrillation are briefly discussed. Two pages are devoted to the identification of ventricular fibrillation and cardiac asystole. There is minimal discussion of cause, prognosis or treatment of arrythmias. However, some of the tracings are quite helpful.

The longest chapter is devoted to cardiac pacing, temporary and permanent, and detecting pacing difficulties by monitor observation. Since the only mode discussed is the fixed rate, seldom used in this country, the chapter is of little value.

This small volume could have been a readily portable reference for nurses, but the simplistic level at which it is written makes it unsuitable for the Canadian nurse. The lack of explanation of the cause of each arrythmia, modalities of treatment and prognostic significance severely limit its value to nursing student or registered nurse.

My personal reaction was one of anger at the condescending tone and both covert and overt implication that nurses were able only to comprehend an extremely simplified presentation. With many superior texts on E.C.G. interpretation and coronary care on the market, this book would serve no useful purpose in any library.

Intensive Care by John Joakim Skillman, M.D., 609 pages. Little, Brown and Company, 1975.
Reviewed by Susan J. Robblee, Teacher, Staff Education, Ottawa Civic Hospital, Ottawa, Ontario.

Dr. Skillman states that the purpose of his book is "to help physicians, nurses, and respiratory therapy personnel improve the care given to critically ill patients." In attempting to meet his goal, the author has included material that ranges from being oversimplified to highly technical. Of fifteen contributors, one is a nurse and the remainder are physicians, so that the emphasis is on medical rather than nursing management of intensive care patients.

The book is arranged in three parts. Part I discusses a specific intensive care unit set-up, the ethical problems and the psychiatric aspects of intensive care. The three chapters are written by physicians for their use. The unit on psychiatric care seems to be particularly helpful to nurses.

Part II is concerned with some of the physiology and pathophysiology of the important body systems presenting problems in a surgical intensive care unit. The chapters are very specific and draw from recent research findings. The sections on cardiovascular responses, respiratory failure, the endocrine system and neurological considerations are comprehensive, but do not refer to nursing care. The chapter discussing body fluids and acid-base balance is both technical and difficult to understand without a broad basic knowledge of the subject.

Sharon Bushnell makes the only nurse's contribution to the book and her presentation leaves me with ambivalent feelings. Certainly,it is a well organized and factual presentation but it lacks the in-depth coverage required for the nursing care of a patient in respiratory failure. Her contribution condenses several chapters from her own book, *Respiratory Intensive Care Nursing*, and as a result some areas, such as auscultation, are treated superficially in Dr. Skillman's book.

Part III is an extension of Part II continuing the discussion of specific problems and their management in a surgical intensive care unit.

The main focus of this book is on medical rather than nursing care. For this reason I would not recommend it as a basic source book for nurses interested in critical care. It would be most useful to nurses as a reference on specific topics of critical care.

Living with Haemophilia by Peter Jones, F.A. Davis. McGraw-Hill, 1975. *Approximate price $11.95.*
Reviewed by Penny Yule, Assistant Head Nurse, Pediatrics, London, Ontario.

Although there are many books written about haemophilia for the use of doctors, "Living with Haemophilia" was written especially for the haemophiliac, his family, and the paramedical worker. Its primary purpose is to meet the physical, emotional, and social needs of the haemophiliac and his family.

Dr. Jones begins his book with a basic introduction of the body systems and their functions. He then focuses on the bleeding process, explaining clotting mechanisms and the cause of bleeding disorders, touching on bo the types and the degrees of severi of the haemophilias.

"Contrary to popular belief, haemophiliacs do not rapidly collaps in pools of blood," states Dr. Jones He then explains the cause and effects of bleeds in areas of the boc most frequently affected.

Therapeutic materials, home therapy, physiotherapy, and dental care are included in the author's discussion of the management of bleeding. He also explains the separation of blood products, the us of local haemostatic agents , antifibrinolytic drugs, and analgesic used in the treatment of bleeding. Dr Jones states, "The earlier the treatme of a bleed is started the better." He then discusses home management specific bleeds, including a description of the home therapy program used by haemophiliacs attending the Newcastle Haemophiliac Centre in Britian.

Physiotherapy is an important aspect of management for the haemophiliac and Dr. Jones describe specific exercises used for various joints. He recommends aids, appliances, and safe arrangement the home to protect the haemophilia from injury.

Preschool activities, education, surgery, employment, sex and fami planning for the haemophiliac are discussed in this book. The author takes into account the attitudes, precautions, and problems encountered in such areas and suggests possible solutions.

Following a brief history of haemophilia, Dr. Jones looks to the future, discussing developments which could alter the present patter of hereditary bleeding such as intrauterine diagnosis and genetic engineering.

"Living with Haemophilia" is writte in a straightforward style in understandable language. It is a boo designed to answer questions the haemophiliac or the layman may hav concerning the disorder. Most important, it emphasizes that the haemophiliac can expect to live a fu normal life.

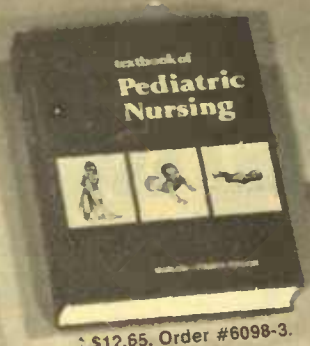
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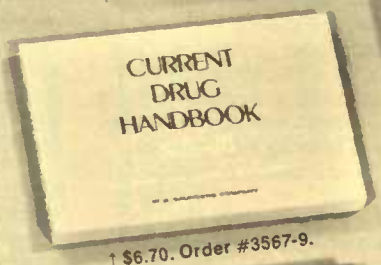
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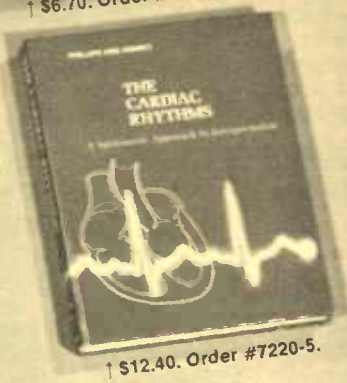
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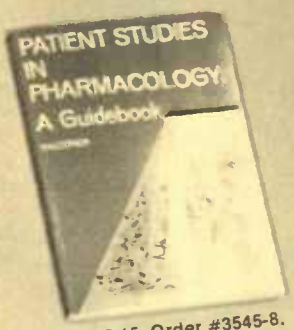
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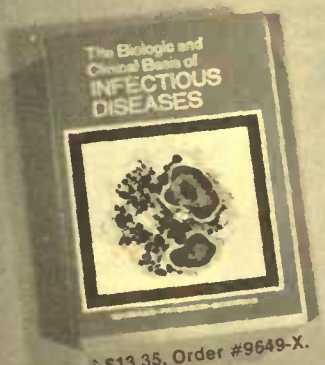
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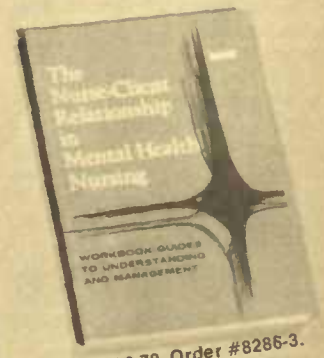
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The Posey Emergency Baby Carrier No. 5420 has been developed to replace potentially harmful evacuation methods. *Approximate price $39.00.*

For further information, contact: Phillip J. White, Marketing Manager, J.T. Posey Company, 39 South Altadena Drive, Pasadena, California 91107.

Techniques for Moving Patients

"Techniques for Moving Patients" is a 16-page employee training manual and poster series. It covers updated methods to reduce employee back injuries, prevent fatigue, and promote patient rehabilitation.

"Body mechanics," patient assessment, and fifteen basic methods to lift active/passive patients are included... in step-by-step procedures. The manual may be used as a self-contained course, or as a mini-text for inservice training classes.

For information write: Dray Publications Inc., Deerfield, Massachusetts 01342.

Trylon Stethoscopes

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Trylon acoustical instruments are permanently magnetically powered and contain no batteries or electric components. They provide more sound output than conventional stethoscopes, and produce a full frequency range of body sounds with a single chestpiece.

For further information write: Raymond B. Molitor, Sherwood Medical Industries, 1831 Olive Street, St. Louis, Missouri 63103.

Disposable Suction

A 1200 cc Dispolex disposable suction collection canister is now available from Air Products and Chemicals, Inc.

Like the larger 2000 cc Dispolex canister, the 1200 cc units provide a tight suction to aid in prevention of cross contamination. This canister also features a frosted surface on which to write patient information. Simple to set up and molded of impact-resistant plastic, Dispolex canisters are easy to use and offer better protection against infection-spreading breakage than do traditional glass suction collection bottles.

The new 1200 cc canister has a measurement feature for accurate measurement of the first 100 cc's of body fluids aspirated. Its compact size makes it particularly convenient for use in the ICU, Recovery Room, and pediatric surgery.

For further information, contact Customer Service Department, Air Products and Chemicals, Inc., Box 538 M, Allentown, Pennsylvania 18105.

Intrauterine Pressure Kit

The new ARGYLE Transcervical Intrauterine Pressure Kit allows monitoring of intrauterine pressure during labor without rupture of fetal membranes. Early rupture of membranes can lead to prolapse of the umbilical cord, and greatly increases the risk of infection if cesarean section proves necessary.

The ARGYLE balloon-tipped catheter is inserted transcervically between the fetal membranes and the uterine wall. When filled with water, the balloon sensor conducts intrauterine pressure to the fetal monitoring unit with the same or better accuracy than an open-ended catheter, but with much less risk to the patient.

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The ARGYLE Transcervical Intrauterine Pressure Kit includes an 80-inch 7 Fr. plastic catheter, plastic insertion guide, and a three-way stopcock. The kit is packaged, sterile, and ready for use.

For more information write to: Sherwood Medical, Dept. TD., St. Louis, MO 63103.

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The new Sage Calculi Strainer is designed to fit into graduated pitchers and most other containers used in laboratories. The strainer is plastic, making it strong enough to be used by one patient for several days, yet inexpensive enough to be thrown away.

The Sage Calculi Strainer has a micromesh filter which holds particles as small as .007".

For further information, write: Sage Products, Inc., 1300 Morse Avenue, Elk Grove Village, Illinois 60007.



Geriatric Chair Safety Bar Kit

A new kit to help prevent patients from sliding and slumping in geriatric chairs, is now available from the J. Posey Company, Pasadena, California.

The Posey Geriatric Chair Safety Bar Kit fits all standard geriatric chairs and uses a soft padded bar to stop the patient from sliding forward while a shoulder "Y" strap counteracts slumping.

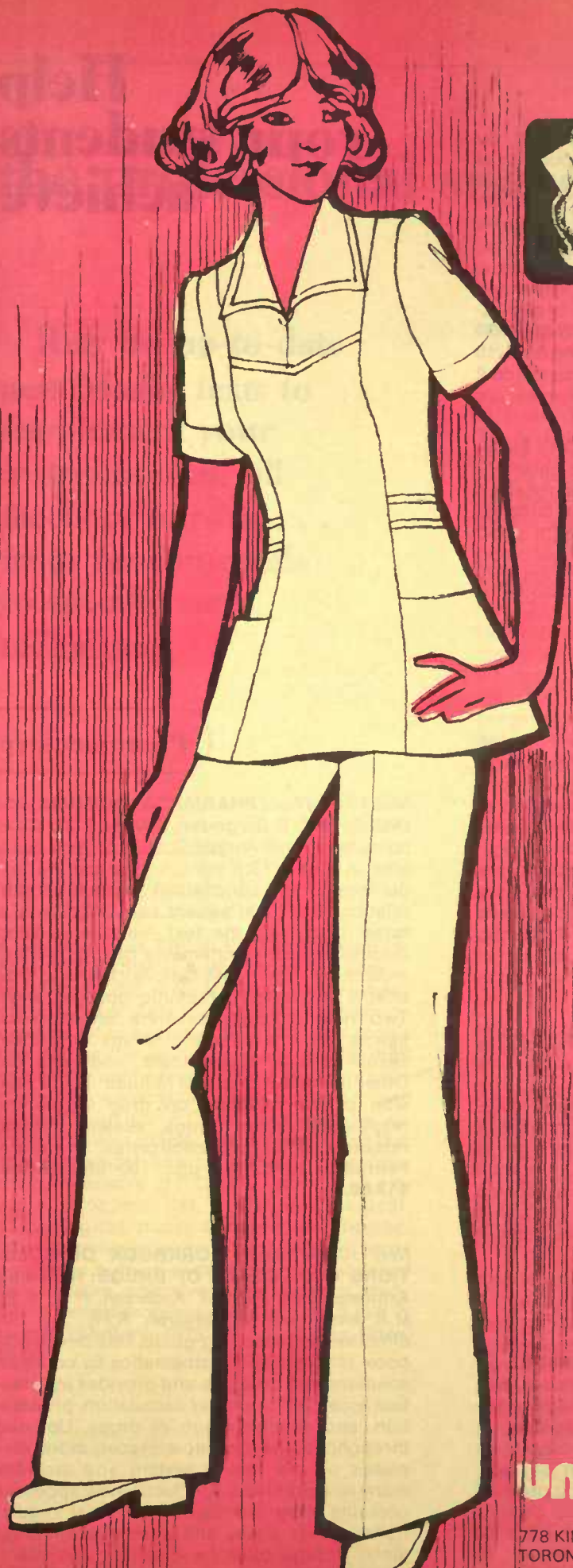
There are three bar models to meet the needs of cooperative, uncooperative and difficult patients. Each kit comes complete and installs in minutes.

A Posey Safety Bar Kit is also available for wheelchairs. Price: Posey Geriatric Chair Safety Bar Kit $31.80 to $41.10 *approximate*. Safety Bars alone: $9.00 to $16.00 *approximate.*

For further information, contact Phillip J. White, Marketing Manager, J.T. Posey Company, 39 South Altadena Drive, Pasadena California 91107.



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Library of Current Practice & Perspectives in Nursing

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New Volume I! **CURRENT PRACTICE IN OBSTETRIC AND GYNECOLOGIC NURSING.** *Edited by Leota Kester McNall, R.N., M.N. and Janet Trask Galeener, R.N., M.S.; with 19 contributors.* Designed specifically for nurses working with OB/GYN patients in community and hospital settings, this new book offers original articles on contemporary issues and patient care. Specific topics include: psychological stress in the last three months of pregnancy; genetic counseling in maternity nursing; aspects of parenthood and the decision not to parent. February, 1976. 270 pp., 39 illus. **Price, $11.05 (C); $7.90 (P).**

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Requests for loans, maximum 3 at a time, should be made on a standard Interlibrary Loan form or by letter giving author, title and item number in this list.

If you wish to purchase a book, contact your local bookstore or the publisher.

Books and documents

1. Alexander, Louis. *Beyond the facts; a guide to the art of feature writing.* Houston, Texas, Gulf, c1975. 263p.
2. Auger, Jeanine Roose. *Behavioral systems and nursing.* Englewood Cliffs, N.J., Prentice-Hall, c1976. 212p. (Prentice-Hall scientific foundations of nursing practice series)
3. Bernstein, Norman R. *Emotional care of the facially burned and disfigured.* Boston, Little, Brown, c1976. 243p.
4. Bouchard, Rosemary Elizabeth. *Nursing care of the cancer patient,* by . . . and Norma W. Owens. 3ed. St. Louis, Mosby, 1976. 313p.
5. Brown, Amy Frances. *Clinical instruction.* Philadelphia, Saunders, 1949. 571p.
6. Bunker, Barbara Benedict. *A student's guide to conducting social science research,* by . . . Howard B. Pearlson and Justin W. Schulz. New York, Human Sciences Pr., c1975. 120p.
7. Canadian Ross Conference on Paediatric Research, Second, Toronto, Nov. 4-5, 1974. *Nutrition of Indian and Eskimo children.* Montreal, Ross Laboratories, 1975. 193p.
8. Conahan, Judith M. *Helping your elderly patients; a guide for nursing assistants.* New York, Tiresias Press, c1976. 128p.
9. Conover, Mary H. *Understanding electrocardiography; physiological and interpretive concepts,* by . . . and Edwin G. Zalis. 2ed. St. Louis, Mosby, 1976. 241p.
10. Conseil canadien d'agrément des hôpitaux. *Guide pour l'agrément des établissements de santé mentale du Canada 1975.* Toronto, 1975. 61p.
11. Dwyer, Joyce M. *Human reproduction; the female system and the neonate.* Philadelphia, Davis, c1976. 209p.
12. *The dying patient; a supportive approach,* edited by Rita E. Caughill. Boston, Little, Brown, c1976. 228p.
13. Emond, R.T.D. *Color atlas of infectious diseases.* Chicago, Ill., Year Book Medical Pub. c1974. 384p.
14. Fensterheim, Herbert. *Don't say yes when you want to say no,* by . . . and Jean Baer. New York, Dell, c1975. 304p.
15. Flitter, Hessel Howard. *An introduction to physics in nursing.* 7ed. St. Louis, Mosby, c1976. 288p.
16. Fourez, Gérard. *Au-delà des interdits; d'une morale de la rencontre à une morale sociale.* Paris, Duculot, c1972. 187p.
17. Fox, David J. *Fundamentals of research in nursing.* 3ed. New York, Appleton-Century-Crofts, c1976. 313p.
18. Francis, Gloria M. *Manual of social psychologic assessment,* by . . . and Barbara A. Munjas. New York, Appleton-Century-Crofts, c1976. 209p.
19. Gladstone, W. J. *Vocabulaire de médecine et des sciences connexes; Anglais-Français et Français-Anglais.* Paris, Masson, 1971. 298p. R
20. —. *Vocabulary of medicine and related sciences; English-French and French-English.* Paris, Masson, 1971. 298p. R
21. Gregg, Walter H. *Physical fitness through sports and nutrition.* New York, Scribner, c1975. 112p.
22. Gunter, Laurie M. *Self-assessment of current knowledge in geriatric nursing; 1,311 multiple choice questions and referenced answers,* by . . . and Jeanne E. Ryan. Flushing, N.Y., Med. Exam. Pub., c1976. 216p.
23. Hall, Virginia C. *Statutory regulation of the scope of nursing practice — a critical survey.* Chicago, The National Joint Practice Commission, c1975. 51p.
24. Jacob, Stanley W. *Elements of anatomy and physiology,* by . . . and Clarice Ashworth Francone. Philadelphia, Saunders, 1976. 251p.
25. Kershner, Velma L. *Nutrition and diet therapy for practical nurses.* 2ed. Philadelphia, Davis, c1976. 266p.
26. Kron, Thora. *The management of patient care; putting leadership skills to work.* 4ed. Philadelphia, Saunders, 1976. 247p.
27. Laurin, Jacques. *Corrigeons nos anglicismes.* Montréal, Editions de l'Homme, 1975. 170p.
28. LeBow, Michael D. *Approaches to modifying patient behavior.* New York, Appleton-Century-Crofts, c1976. 383p.
29. Maddison, David D. *Psychiatric nursing,* by . . . Patricia Day and Bruce Leadbeater. 4ed. Edinburgh, Churchill Livingstone, 1975. 532p.
30. Marram, Gwen D.A. *Cost-effectiveness of primary and team nursing,* by . . . et al. Wakefield, Mass., Contemporary, c1976. 91p.
31. Miller, Michael B. *The interdisciplinary role of the nursing home medical director.* Wakefield Mass., Contemporary, c1976. 296p.

Calendar

October

Septic Shock-Incidence and Implications. A seminar presented by the Winnipeg Association of Critical Care Nurses on October 20, 1976. For further information, contact: *Ms. Eleanore Warkentin, 7D-1790 Portage Ave., Winnipeg, Manitoba, R3J 0E9.*

Order of Nurses of Quebec — Annual General Meeting, to be held at the Queen Elizabeth Hotel, Montreal, October 27 - 29, 1976. For information, contact: *ONQ, 4200 Dorchester Blvd., Montreal, Quebec.*

6th Annual Pediatric Seminar-"Experiences for Learning" to be held at the Gertrude M. Hall Education Wing, Calgary General Hospital, Calgary, Alberta on Oct. 28-29, 1976. For further information, contact: *Faye Ferguson or Donna Lenties, Alberta Children's Hospital, 1820 Richmond Road, Calgary, Alberta.*

Nursing and the Law a workshop for nurses and other health professionals to be held on October 23, 1976. Speaker: Lorne Rozovsky, Department Solicitor of Nova Scotia Health Services and Insurance Commission. For further information contact: *Norma J. Fulton, Director of Continuing Nursing Education, University of Saskatchewan, Saskatoon, Sask.*

November

Reality Orientation Workshop to be held at the Faculty of Nursing, University of Toronto on Nov. 10 - 11, 1976. Fee: $60.00. For further information contact: *Mrs. Dorothy Brooks, Chairman, Continuing Education Programme, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ont., M5S 1A1.*

Scientific Writing Workshop for Nurses to be held at the Faculty of Nursing, University of Toronto on Nov. 25 - 26, 1976. Fee:$50.00. For further information contact: *Mrs. Dorothy Brooks, Chairman, Continuing Education Programme, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ont., M5S 1A1.*

Tuberculosis and Emphysema Today. A one day seminar for nurses, physiotherapists, respiratory technologists and other interested health professionals. To be held at the Town Hall, Newcastle, N.B., on November 17, 1976. No registration fee. For further information, contact: *Mrs. Alma Leclerc, Program Director, New Brunswick Tuberculosis and Respiratory Disease Association, Box 1345, Fredericton, N.B. E3B 5E3.*

Canadian Intravenous Nurses Association - Seminar and Product Fair to be held at Sunnybrook Medical Centre, Toronto, Ontario on November 17-18, 1976. For further information, contact: *C.I.N.A., Box 481, Station Z, Toronto, Ontario, M5N 2Z6.*

32. National Association of Parliamentarians. *Blue book 1973-1975.* Kansas City, Mo., 1975. 144p. **R**
33. National League for Nursing. *Collaboration in health care education.* New York, 1976. 65p. (NLN Pub. no. 23-1617)
34. —. *Coping with change through assessment and evaluation.* New York, 1976. 104p. (NLN Pub. no. 23-1618)
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Announcement — Who Fellowships 1976 — 77

The World Health Organization allocates each year a small number of fellowships to Canadian Health Workers. Awards will cover per diem maintenance and transportation. The fellowships are used to provide short programs of study abroad of approximately 2 to 3 months' duration.

Canadian citizens engaged in a professional capacity in operational or educational aspects of health care are eligible to apply. Ineligible are workers in pure research, undergraduate and graduate students and applicants more than 55 years of age.

Applicants will be rated and chosen by a selection committee on the basis of their education and experience, the field of activity they propose to study and the intended use of the knowledge gained during their fellowship upon return to this country. Final acceptance will remain the responsibility of WHO.

Requests for further information should be directed at the earliest opportunity to International Health Services.

International Health Services
Jeanne Mance Building
Tunney's Pasture
Ottawa, Canada
K1A 0L2

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Address correspondence to:

The Canadian Nurse

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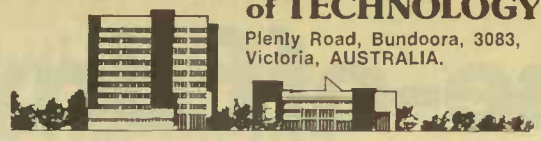
Local interviews across Canada will be conducted in late October. For an appointment, call collect now. Contact Anne Moroziuk, R.N., Nurse Recruiter, Stanford University Hospital, at (415) 497-7330. If you won't be available for a personal interview, please send your resumé to Anne Moroziuk, R.N., Nurse Recruiter, Stanford University Hospital, Stanford, CA 94305.

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Lecturers: (6 positions) Salary range: $A11,425 — $A17,727 annually. Appointments will be made within this range depending on qualifications and experience.
Possession of a degree in nursing is desirable but applicants with other degrees and/or diplomas who have relevant nursing experience may be considered.
Applicants must be willing to make meaningful contributions to a developing nursing department. Each lecturer will have an area of responsibility, related to his/her particular interest and expertise, will share in the general teaching activities and will be expected to teach and supervise nursing students within the hospital and community setting.
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Applicants should forward a curriculum vitae, including personal details qualifications and experience to the Staffing Officer, (Ref.f. 189).

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Box 31, Islington, Station B
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Competition is open to both men and women.
Please quote competition number 76-525.

Application forms may be obtained from the Civil Service Commission, J.W. Johnston Building, P.O. Box 943, Halifax, Nova Scotia, B3J 2V9, and from the Provincial Building, Sydney, Nova Scotia, B1P 5L1.

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Medical Services Branch
Department of National Health and Welfare
Ottawa, Ontario K1A 0L3

Name

Address

City Prov.

Health and Welfare Canada Santé et Bien-être social Canada

Medicine Hat & District Hospital

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These are senior positions. Co-ordinators report directly to the Assistant Executive Director — Patient Services.

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Submit Resume To:

Mrs. Gwynneth Paterson
Assistant Executive Director — Patient Services
Medicine Hat & District Hospital
666 Fifth Street, South West
Medicine Hat, Alberta T1A 4H6

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A2V 2K1

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Winnipeg, Manitoba
R3J 3M7

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requires
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with background in
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Harbour Breton
(Pool's Cove), Fortune Bay
Jeffrey's
Labrador City/Wabush
Lourdes, Port au Port
Musgrave Harbour
Springdale, Notre Dame Bay
St. Alban's, Bay d'Espoir
St. George's, St. George's Bay
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Department of Health
Confederation Building
St. John's



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5' 1"	95-145 lbs.	———	150-185 lbs.
5' 2"	90-140 lbs.	141-150 lbs.	155-190 lbs.
5' 3"	90-135 lbs.	136-155 lbs.	160-195 lbs.
5' 4"	95-130 lbs.	131-160 lbs.	165-195 lbs.
5' 5"	100-125 lbs.	126-165 lbs.	170-195 lbs.
5' 6"	105-120 lbs.	121-165 lbs.	170-190 lbs.
5' 7"	110-115 lbs.	116-165 lbs.	170-185 lbs.
5' 8"	———	115-160 lbs.	165-180 lbs.
5' 9"	———	120-150 lbs.	155-175 lbs.
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News

Newfoundland nurses hold twenty-second annual meeting

Nursing in Canada's youngest province and the direction the profession will take over the next few years, came under close scrutiny during the 22nd annual meeting of the Association of Registered Nurses of Newfoundland. Close to 400 nurses attended the meeting in St. John's from September 27 to 29.

During the meeting they heard outgoing ARNN president, Roberta Clegg, assistant administrator of nursing service, International Grenfell Association, St. Anthony, Nfld., make a strong plea for better health care for the "pioneer of today who feels he has the right to adequate medical services while he is engaged in opening up the resources." She urged nurses in the urban areas of the province to remember that their actions also affect the nurse in isolated areas and pointed out that unless they have strong family ties most of these nurses are reluctant to work in the outports. She encouraged ARNN members to act collectively to obtain increased nursing enrolment in the province, equal education opportunities for children in northern communities and nursing education programs more directly relevant to the health needs of people in the outports.

Canadian Nurses Association executive director, Helen K. Mussallem, reminded nurses at the meeting that membership in their professional association constitutes one of the "hallmarks of the professional." Other criteria she named include: a flexible education base; a code of ethics; commitment to continuous learning; mastery of fundamental skills and accountability.

"If we consider ourselves an independent profession, we must also consider ourselves accountable for all our acts," she said. Mussallem was guest speaker on the opening day of the meeting. She replaced CNA president Joan Gilchrist who was unable to attend.

Reviewing the goals and accomplishments of organized nursing in Canada, Mussallem remarked that "it is no accident nurses in this country have never been as well prepared as they are now to make long range decisions." She also reminded her audience that the establishment in each province of collective bargaining organizations did not release professional associations from their obligation to obtain satisfactory social and economic working conditions for their members.

In order to meet rising costs of maintaining a professional association and to provide professional liability insurance for nurses in the province, ARNN members approved a $20 increase in association fees. Active membership next year will cost nurses $60; the fee for inactive members will be $7.50.

In other business during the meeting, members approved an amendment to the Association bylaws making it compulsory for all nurses from outside Canada and the United States who have not written and passed CNATS or NLN examinations to write Canadian examinations after January 1, 1978. After that date, nurses from outside Canada and the United States wishing to practice in Newfoundland will have to write the Canadian exams within six months of arrival and must obtain a score of at least 350.

Council members for 1977-78 w be as follows;
Executive— Violet Ruelokke, president; Margaret D. McLean, president-elect; Elsie Hill, first vice-president; Gertrude Caines, second vice-president; Roberta M. Clegg, immediate past-president.
Councillors — Beverley Andrews; Janette Ball; Judith Chubbs; Myrtle Cummings; Marcella Linehan; Ada Simms.
Chapter Representatives will Include: Elitina Clarke, Corner Brook Imelda Head, Grand Falls; Hilda Jewer, Gander; Minnie Pelley, Labrador City/Wabush; Janet Greer Trinity/Conception; Frances Bouzan Stephenville; Arthura Squires, Burin Peninsula; Bessie Facey, Triple Island; Dorothy Sutcliffe, St. Anthony
Non-voting Members will be: Phylli Barrett, executive secretary; and Alic Furlong, assistant executive secretary.

Did you know ...
Canada's population passed 23 million on April 1, 1976, according t estimates by Statistics Canada.



Photo by Studio Impact

The Extension Course in Nursing Un Administration held its Ottawa workshop September 20-24, 1976 a the Chateau Laurier with 78 student from northern and eastern Ontario and Quebec attending the session This nine-month in-service course consists of an initial workshop, hom study with correspondence lessons and a final workshop. Each year, more than 500 nurses from across Canada attend NUA workshops in seven Canadian cities. The progra is offered both in English and Frenc and has also been initiated in other countries. All participants are nurse who are employed full time in managerial positions in hospitals an community agencies. The NUA course, begun in 1960, is sponsore jointly by the Canadian Nurses Association and the Canadian Hospital Association.

University of Toronto terminates nurse practitioner course

This year, the University of Toronto will end its continuing education course for nurse practitioners, reportedly for lack of funds. The University of Toronto program was funded as a research project by the Research Program Development Directorate of Health and Welfare Canada from 1972 to 1975, and the grant was renewed for 1975-76.

The program was developed by the faculties of medicine and nursing at U of T. Requests for further funding, directed to both federal and provincial governments, were unsuccessful.

Last December, U of T requested the financial support of the Ontario Ministry of Colleges and Universities, a request that was turned down because it came too late, and because of budget cuts. Murray Tarleton, program analyst for the university affairs division of the Ministry, suggested that funds were not forthcoming "because we were advised by the Ontario Ministry of Health to wait until the qualifications of the nurse practitioner and our manpower needs are resolved." He said "There might be a surplus of doctors in Ontario."

Kathleen King, Dean of the Faculty of Nursing at U or T and R. Brian Holmes, Dean of the Faculty of Medicine, state that the termination of the course does not mean that U of T no longer prepares nurses for expanded roles in health care. "The degree programs in nursing have for some years placed emphasis on clinical nursing skills rather than teaching or administration ..."

The demise of the U of T program means that McMaster University in Hamilton will be the only center for educating nurses practitioners in Ontario. A course at the University of Western Ontario in London trains northern nurses, but does not ...der them nurse practitioners.

Nurse practitioners have been ...ed for an expanded role — for ...ork in isolated communities, as ...ained assistants in physicians' ...ffices and in other settings. Their ...ositive role in monitoring treatment, assessing problems, assisting in home care and health education has been well-documented. A recent *Globe and Mail* editorial criticized the government's role in the whole question of health care delivery, suggesting that if prevention and cutting health care costs are government priorities, the lack of government financial support of the nurse practitioner course is a "foolish and uneconomic way to proceed."

The program at McMaster University is still going strong, financed by a three-year grant received from the Ontario Ministry of Colleges and Universities effective last May. The program is directed towards nurses and physicians practicing in a number of primary care settings including family medical practices, community health centers and occupational health settings. Dr. Dorothy Kergin and Dr. Fraser Mustard of the Faculty of Health Sciences at McMaster, state: "McMaster research studies concerned with the utilization of these primary care teams have demonstrated a high level of acceptance by patients, personal satisfaction on the part of the practitioners, and most importantly, a pattern of increased care on an ambulatory basis and a lesser tendency for care in the hospital, except for serious problems which clearly require these more highly specialized resources. In our view it is in the area of reduced hospital costs where the true dollar savings lie."

In their letter to the *Globe and Mail* Kergin and Mustard point out that three reports emphasizing the importance of the nurse practitioner in primary care, have been submitted to the Ontario Ministry of Health. These include the Report of the Health Planning Task Force (1974), a report following a conference of the Ontario Council of Health (January, 1975), and an Ontario Council of Health Report on the Evaluation of Primary Care Services (1976). The reports have been submitted — the Ontario government still has no stated policy regarding the future of nurse practitioners in Ontario.

Health happenings

Canada's Minister of National Health and Welfare, the Hon. Marc Lalonde says his department has now embarked on **"Operation Lifestyle"** — an over-all education program designed to encourage Canadians to assume greater responsibility for health. He told delegates to the Seventh International Congress of Medical Records in Toronto in September that positive gains in health for Canada depend upon encouraging individuals to modify adverse lifestyles.

A Lifestyle Profile which will enable individuals to determine the quality of their lifestyle and see where improvement is needed, is part of the new program, as are the Lifestyle Awards which will soon be instituted to honor Canadians making a significant contribution to health through their own lifestyles.

Other features include the Department's Fit-Kit and Dialogue on Drinking, a health education program aimed at reducing excessive alcohol consumption, as well as plans for emphasis on industrial safety, a cleaner environment and safety measures to reduce injuries and deaths associated with traffic accidents.

Eighty-year-old comedian George Burns, who says he knows some people who were 75 when they were 25 years old and figures this makes him about 32, was guest of honor recently at **Baycrest Geriatric Centre in Toronto.**

Burns was chosen by the Centre to be the first recipient of its new "Life Begins at 65 Award." His comment on the subject of geriatrics: "I know lots about old age but little about death. I never died before, except in Schenectady."

A kidney transplant program involving four hospitals in Metro Toronto is expanding to acquire body organs from all over Ontario and neighboring states in the U.S.

Dr. Michael Robinette, chairman of the Metro Organ Retrieval and Exchange Program, says the program will use a station wagon donated by an auto manufacturer to carry medical teams, which will be on 24-hour call whenever a body becomes available.

Directory of member associations

Registered Nurses' Association of British Columbia 2130 West 12th Avenue, Vancouver, B.C. V6K 2N3. *Executive Director* - F.A. Kennedy

Alberta Association of Registered Nurses, 10256 - 112th Street, Edmonton, Alta. T5K 1M6. *Executive Secretary* — Helen M. Sabin.

Saskatchewan Registered Nurses' Association 2066 Retallack St., Regina, Sask. S4T 2K2. *Executive Director* - Valerie Cloarec

Manitoba Association of Registered Nurses, 647 Broadway Avenue, Winnipeg, Man. R3C 0X2. *Executive Director* - M. Louise Tod

Registered Nurses' Association of Ontario 33 Price Street, Toronto, Ontario, M4W 1Z2. *Asst. Executive Director* - Doris Gibney

Ordre des infirmières et infirmiers du Québec (Order of Nurses of Quebec), 4200 Dorchester ouest, bd, Montreal, Quebec H3Z 1V4. *Executive Director and Secretary of the Order* - Nicole Du Mouchel

New Brunswick Association of Registered Nurses, 231 Saunders St., Fredericton, N.B. E3B 1N6 *Executive Secretary* - Karon Croll

Registered Nurses' Association of Nova Scotia, 6035 Coburg Road, Halifax, N.S. B3H 1Y8. *Executive Secretary and Registrar* - Frances M. Moss

Association of Nurses of Prince Edward Island 188 Prince Street, Charlottetown, P.E.I. C1A 4R9. *Executive Secretary-Registrar* - Laurie Fraser

Association of Registered Nurses of Newfoundland 67 LeMarchant Road, St. John's, Nfld. A1C 6A1. *Executive Secretary* - Phyllis Barrett

Northwest Territories Registered Nurses Association, Box 2757, Yellowknife, N.W.T. X0E 1H0. *Secretary-Treasurer* - Jeanette Plaami.

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A New Book! **THE PROBLEM-ORIENTED PSYCHIATRIC INDEX AND TREATMENT PLANS.** *By Monte J. Meldman, M.D.; Gertrude McFarland, R.N., M.S.; and Edith Johnson, B.A.* This dynamic new text exemplifies a new way to standardize psychiatric treatment and improve the delivery of health care services. This index — a systematic listing of problems, goals, and treatment methods — enables all members of the mental health team to *coordinate, integrate,* and *record* the multiple aspects of prevention, diagnosis, treatment, and rehabilitation into a comprehensive prescription for care of the individual and his family. Initial sections provide a general description of the indexing system and subsequent chapters review the chronological order of service delivery. July, 1976. 212 pp., 88 illus. **Price, $7.90.**

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HUMAN SEXUALITY IN HEALTH AND ILLNESS. *By Nancy Fugate Woods, R.N., M.N.; with 1 contributor.* This informative new book illustrates ways in which health professionals can deal successfully with a patient's sexual needs, fears, and self-image. Lucid, well-written discussions examine human sexual response patterns in a life cycle framework; adaptation to events that threaten sexual integrity; and adjustment to disease and disabilities that interfere with sexuality and sexual function. Important concepts on sex education and counseling are also provided. 1975, 242 pp., 7 illus. **Price, $7.65.**

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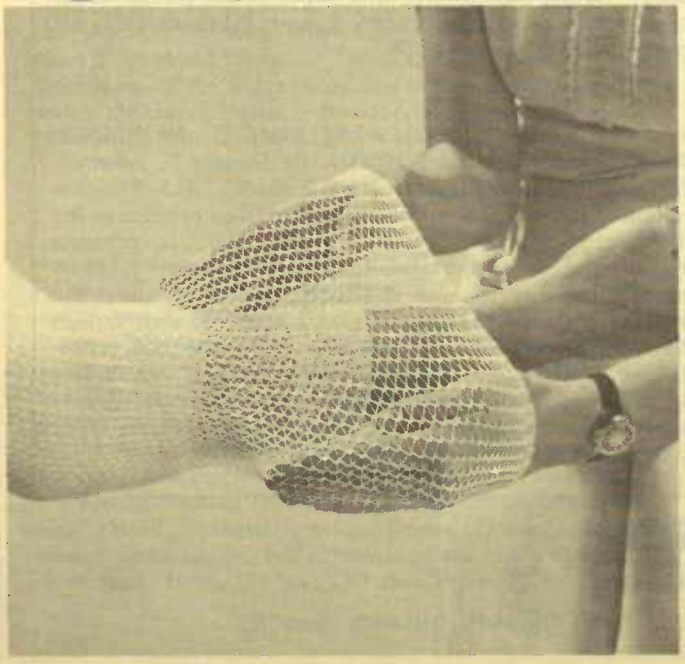
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Changes mean broadening our horizons. We can help to make comprehensive health care more than just a cliché.



mr. jones
FROM HEAD TO TOE



Lynda Foro

Within a brief eight to twelve-hour period, a nurse often has a great deal to do. There are patients, relatives, doctors, nurses and technicians to talk to; there are blood tests and X rays and ORs to arrange. There are patients who need a listener and those who require her teaching. There are charts to read, blood results to know, medications and treatments to give, vital signs to take, and procedures to assist in. (And) That phone is ringing again...
"How is Mr. Jones today?"

In September, *The Canadian Nurse* published an article on the 'Head to Toe' method of assessment and charting. What follows is a specific example of its use in an intensive care unit. The emphasis in this follow-up article is not on treatment, which often varies dramatically from setting to setting —but on a method of nursing assessment and its implementation through charting.

The method involves looking at the patient systematically, observing and charting all that there is to be seen. Used in conjunction with the monitoring of vital signs, fluid balance, and test results, it forms the basis for informed and total patient care from a nursing and medical standpoint.

The case history presented here is sketchy — it does not attempt to give the rationale for treatment nor to describe nursing care. The focus of this article is on the first half-hour or so of the nurse's day with Mr. Jones. At 0730 hours on the first postoperative day, she receives report from the night nurse.
The following is her 'Head to Toe' assessment of Mr. Jones.

Post-op Day 1

Mitral and aortic valve replacement

0730 hours:

Received patient sedated on MA1 * ventilator

* *MA1 is a registered trademark of Puritan-Bennett Corporation.*

I would like to thank the nursing staff of the Cardiothoracic Unit at the Vancouver General Hospital for sharing the 'Head to Toe' check with us. I would also like to thank Kathi Olsen, Assistant Head Nurse of ICU at St. Michael's Hospital, Toronto, for sending us 'Mr. Jones' for assessment.

Head:

— Sleeping, rouses easily to light touch.

— Pupils equal, medium in size, reacting briskly to light.

— Moves four limbs to command.

— Hand grips — moderately strong and equal.

— Leg movements — strong and equal. Sensation good.

— Color — pink to ears, lips, and nail beds.

Chest:

— On MA1 * ventilator. 40% O_2, tidal volume (T.V.) 700 cc, respiratory rate (R.R.) 15/min, self trigger (S.T.), airway pressure 20 cm H^20.

— No. 9 endotracheal tube (E.T.T.) in situ, cuff inflated.

— Chest expansion equal bilaterally. Air entry audible to both apices and bases; moist breath sounds throughout. Suctioned for small amounts white sputum per E.T.T.

— Apex strong, clear, regular.

— Chest incision dressing dry and intact.

— Mediastinal and pericardial chest tubes in situ, draining scant amounts sero-sanguinous fluid.

— Pleur-evac * set at 20 cm suction.

— Pacer wires in situ; temporary demand pacemaker set at rate 90/min., milliamperes 5 and turned off.

Abdomen:

— Soft, rounded, no bowel sounds audible.

Extremities:

— All peripheral pulses palpable, moderately strong.

— Feet pink, cool to touch. Slight pitting edema of ankles bilaterally.

Skin:

— Warm and moist. Heels, elbows and coccyx slightly reddened; no skin breakdown noted. No sacral edema noted.

Pleur-evac is a registered trademark of Deknatel Inc.

Equipment:

— IV's

1. 1000 cc 5% DW infusing at 75 cc/hour via CVP line in the right anticubital fossa. CVP fluctuating well for readings

2. 250 cc 5% DW running via left hand site to keep vein open (TKVO)

3. xylocaine drip: xylocaine 1gm/500 cc 5DW to control premature ventricular contractions (peripheral line) on standby, and turned off.

— Arterial line: right groin, patent, (flushed q1h with heparinized saline). Dressing dry.

— ECG: showing regular sinus rhythm, rate 80/min.

— Foley catheter: no. 16, 5cc ballon — in situ, draining clear amber urine at 20-30 cc/hour.

— Nasogastric tube: No. 14 — in situ, patent, and draining moderate amount bile-colored fluid to intermittent suction.

Vital Signs:

— charted on the parameter record. BP 130/90, apical rate 80/min., CVP16 cm H_20, R.R. 15/min., temperature 37.6 rectally.

0800 hours:

The 'Head to Toe' check gives the nurse a good idea of how Mr Jones is doing. It also provides the nurse with an opportunity to reassure him and initiate care as she goes about her assessment. His current status can be compared with previous charting; it can also be used as a baseline for further assessment of his improvement or deterioration, and for nursing priorities.

Today Mr. Jones is relatively comfortable, showing no major signs of developing problems or unusual distress. The equipment he depends upon is functioning well. His morning chest X ray indicates that his chest is clear, and his blood gas results are within the normal range on 40% 0_2.

Biochemistry results are normal, urinary output adequate. His cardiovascular signs are stable; he is ventilating well and responds well to verbal and non-verbal stimuli. Mr Jones will be very closely monitored until his condition stabilizes. Within a few days, barring complications, ventilation will be discontinued, his chest tubes removed, IV fluids discontinued (with increased oral intake) and he will be up and around. The 'Head to Toe' check will be altered as his condition improves, with an emphasis on his rehabilitative progress.

The Patient

Bill Jones, a 58-year-old plumber, was fairly healthy until three years ago, when he began to experience an unusual sense of fatigue and shortness of breath on any physical exertion. His doctor diagnosed pericarditis, the symptoms of which resolved with treatment and time. Over a period of three years, Bill was able to lose fifty pounds by watching his diet. However, he continued to smoke rather heavily. He took Digoxin 0.25 mgm once a day, and Lasix 40 mgm twice daily as ordered by his doctor.

This spring, Bill began to notice increasing shortness of breath, forcing him to cut back on his smoking. Soon he required three pillows to support him if he wanted to get any comfortable sleep at all. He had no chest pain.

Investigation through coronary angiography showed that Bill Jones had both mitral and aortic valve insufficiency, but no coronary artery disease. Consequently, he had a double valve replacement, with no problems arising during the surgical procedure itself.

When transferred from surgery to ICU, Mr. Jones was still not awake, but his cardiovascular signs were stable, and his cardiomonitor showed no arrhythmias.

Immediately following surgery, the plan included monitoring of his vital signs, ventilation, blood transfusions for hypovolemia, and sedation to keep him comfortable.



Stepping Stones: A ROAD to Coronary Rehabiliation Programs

Penny Jessop

The concerns of the nursing profession have traditionally focused on the patient who is acutely ill. Only recently has positive rehabilitative health education been accepted as a vital component in comprehensive care. Now it is up to us to help in providing an opportunity for the exchange of questions and answers, in initiating and coordinating in-hospital/post-hospital programs, and in structuring the environment in such a way as to make rehabilitation more than just a possibility.

Within the past year, the Ontario Heart Foundation through its Public Education Director, has acted as a resource and consultant in the establishment of 14 post-hospital teaching/support programs in Ontario. These programs are basically designed to meet the health education needs of cardiac patients and their families following hospitalization. Though basic core content is similar, each area has an individualized plan to allow health educators to meet the priority concerns of their area, to incorporate local medical preferences, and to utilize their own community resources most effectively. What follows is an outline of the program; it includes the basic concepts underlying our learning/teaching philosophy, considerations in program development, the experience of implementation, and methods of program evaluation.

Basic concepts

In setting up our programs we realize that effective teaching, particularly regarding rehabilitation, must recognize the unique quality of each person we hope to teach. Realizing the importance of relating to people as individuals, there remains a common approach to the rehabilitation plan for each patient. Our philosophy then, recognizes that:

- The patient's readiness to learn is always there.
- Only facts presented in an effective environmental structure will become knowledge.
- A positive approach is best, emphasizing *health* promotion needs as opposed to *disease* orientation.
- Observation of phases through which the post-coronary patient and his family pass will help to organize the teaching plan.
- Assessments must be made not only of what was taught, but also what the patient demonstrates he has learned.
- Success cannot be expected 100 percent of the time. In teaching we can convey the information, let the patient and family know what they are to do with that information, and provide the environment for reinforcement. The aims and objectives must be realistic – for the learner and for the teacher.

Program Development

In planning a post-hospital teaching program, it makes sense to find out what has been discussed with the patient and family during his stay in hospital. This will form the baseline from which the post-hospital teaching staff can select topics for their program. For this reason, a simple checklist used during the patient's stay (see Figure I) coupled with the admission history and discharge summary, offer those concerned with the patient's follow-up a starting point for their teaching.

The initial development of a double set of objectives is helpful in facilitating evaluation of the program. Both patient-centered (including the family) and program-oriented aims should be developed. In several instances, these aims may overlap. For example, it is hoped that the implementation of a teaching plan will decrease readmission rate. This program-oriented aim can be measured by a readmission data flow sheet recording the patient's readmission diagnosis, duration of time since discharge, his age, and problems existing on discharge which could have contributed to his readmission.

The corresponding assessment needed in a patient-centered review would relate to the actual learning accomplished through the post-coronary teaching. Hopefully such



teaching will change the individual's behavior and avoid the development of complications leading to readmission. These could include non-compliance with his medication, nutritional or exercise regime; development of congestive heart failure; post-coronary anxiety; or family non-acceptance.

Once determined, the objectives will indicate the need to include several associated disciplines. A suggested initial planning committee will include a physician-consultant, a critical care nurse, psychologist or social worker, nutritionist, pharmacist, physiotherapist, chaplain, public health nurse, home care nurse, and industrial health nurse. A meeting of members of the involved disciplines should be held to plan the various topics of a post-hospital discussion series, drawing from specific areas of expertise. The first meeting can lay the philosophical groundwork for the program, and it acts as an introductory meeting for those to be involved in the program.

Hesitancy is sometimes expressed by those who want to become involved in the program planning. One of the concerns expressed is over stereotyping of information given to the patient and his family; another centers on the advisability of patients getting together to 'compare notes' about their cardiac event. It must be emphasized that the intent of a post-hospital support program is just that — support. Initially, planning is done in general terms — experience has taught us that there are certain major learning concerns that need reinforcement.

Group discussions are designed to be led by a specialist for each topic. Such discussions are carefully observed and evaluated. We have found it helpful to have one member of the planning team act as a chairman or coordinator of all group discussions to bring cohesiveness and consistent leadership to the program.

Our present programs cover a variety of topics, but there are many topics common to all programs. The areas discussed are those most often needing post-hospital reinforcement including basic anatomy and physiology, nutrition, multi-factor risks, medications, activity, sexuality, stress, work evaluation, and life-style review. These are the real issues of daily life, not those of a protective clinical environment.

The program is presented to Medical Advisory Boards, the local Academy of Physicians, and various community assistance branches for recognition. Additional revision of the program may be necessary following the response of these groups. It takes approximately six months following initial planning for the program to be ready for implementation.

Implementation

Once the groundwork is laid, details concerning place, time, number of sessions, group leaders, and public relations can be worked out.

It is not advisable to try to "catch up" on the many cardiac patients and their families who have never had the opportunity to attend a discussion series. Usually, patients eligible for the program (within the subscribing hospitals) are notified two to four weeks prior to their discharge from the hospital. They may be informed of the program during in-hospital patient teaching programs, by the hospital's discharge planning officer, or by a special notice given to patients and staff.

We have found it most convenient for those attending the sessions as well as for volunteer discussion leaders to arrange early evening sessions, approximately one and a half hours in length. Once the time for groups has been established, a roster of discussion leaders is developed, with one member of the planning committee attending all discussions to add cohesiveness through reference to past sessions. Time is arranged for a structured review of the evening's topic, followed by a question period, open discussion, and friendly conversation. Sometimes, the group may be divided to encourage patients and family members to express their thoughts in separate groups. A total group size of no more than 24 has proven most satisfactory.

A centrally located setting outside of the hospital seems to be most effective as a meeting place. Discussions have been



Figure 1

CORONARY HEALTH TEACHING RECORD

Date Teaching Started: _____

Assessment of Previous Knowledge: _____

Level of Knowledge about Condition on Discharge: _____

PATIENT ASSESSEMENT

TOPIC			Date Taught	Adequate Comprehension	Apprehensive	Needs Review	Little or No Comprehension	Relative Present	Comments
Basic Anatomy Review									
Basic Physiology Review									
Diagnosic Tests									
Identification of Risk Factors									
Heart Attack/ Angina									
Concept of Rehabilitation (multifactor)									
Atherosclerosis									
Nutrition									
Obesity									
Exercise & Activity									
Lifestyle & Occupation									
Physical Stress									
Psychological Stress									
Sexual Relations									
Hypertension									
Age & Heredity									
Medications									
Smoking									
Signs & Symptoms of Complications									

conducted in local libraries, church rooms, school rooms, and municipal government offices. These places often have their own film and slide projectors, blackboards, tables and chairs. Easy access must always be kept in mind for patient convenience.

The choice of an extra-hospital location seems to allow greater freedom of discussion. A hospital setting suggests the possible return to the 'patient role.' This atmosphere is eliminated through the use of an extra-hospital setting, where the focus on return to a healthful lifestyle is more easily established.

Evaluation

In order to make any progress with rehabilitative programs, those involved in planning must continually assess their effectiveness. It is estimated that readmissions for cardiac patients have decreased by 30 percent, and that patient compliance (activity and medications) has risen to 88 percent through long-term rehabilitation regimes.*

In assessing the programs set up by the Ontario Heart Foundation, we consider the following questions:

1. is there a measurable change in the number of patient readmissions since the establishment of the program?
2. are we attaining the program-oriented goals established at the onset of the program?
3. is the patient indicating that he has learned from his involvement in the program?

The effectiveness of the program is assessed by comparing readmission rates before and after the program was begun, i.e.:

- the number of readmissions within the first eight weeks post-discharge (how many were repeatedly admitted, and how many times each?)
- readmission diagnosis as compared to initial diagnosis
- age, sex, occupation, marital status of re-admitted patients
- how many of the readmitted patients had been seen by their family doctor, a specialist, or a community health nurse prior to readmission?

These statistics, plus a record of the telephone enquiries received from cardiac patients or their families by hospital staff over a six month period provide a good baseline for comparison to show us what we have, in fact, accomplished.

Evaluation of the program-oriented goals is facilitated by writing out these goals at the beginning of the program. The initial six months of the program can be assessed through the use of a flow-sheet.

Patient assessment can be accomplished by asking patients to evaluate themselves — have they, in fact, attained desired changes in attitudes or behavior? Self-evaluation serves the useful purpose of reinforcing what has been taught. Measurable criteria might include:

- weight reduction/cholesterol reduction
- medication compliance
- smoking cessation
- corrective modifications in nutritional pattern
- change in response to stresses
- recording of activity program
- preventive measures taken by other family members.

In weighing the merits of the program, we can also measure its cost by examining nursing and patient care hours involved, the patient's average length of stay in hospital, and the investment involved in continuing education for staff to help them to become more effective teachers.

Nursing responsibilities are by no means over when the patient leaves the hospital. Limitations in time mean that we can only accomplish part of the rehabilitation process while the patient is hospitalized. It is hoped that the post-hospital cardiac teaching sessions will give reinforcement, review and support to the patients after their discharge, and will offer a long-term and meaningful approach to rehabilitation.

* *In conjunction with programs at St. Joseph's Hospital, Chatham, Ont., and York Central Hospital, Richmond Hill, Ont.*

The author acknowledges appreciation for the work and interest of those involved in the teaching/support programs of Chatham, Cornwall, Kitchener-Waterloo, Richmond Hill, Hamilton, Windsor, Scarborough, Etobicoke, and Sudbury.

Penny Jessop(R.N., St. Mary's School of Nursing, Kitchener, Ontario; B.Sc.N., University of Ottawa) has extensive experience in nursing education. She has been Nurse Clinician in the intensive care unit of the Kitchener-Waterloo Hospital and in the Department of Ambulatory Care, Hamilton, Ontario. At present she is the Director of Public Education for the Ontario Heart Foundation.

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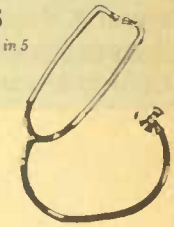
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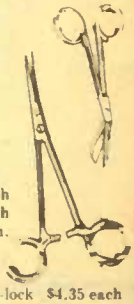


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Heart disease, with its related illnesses, afflicts and kills more people than any other single health problem. The statistics are staggering, but even more staggering is the fact that health professionals allow their patients and families to leave the hospital setting without knowing what has happened to disrupt their lives, and what to do about it. People with cardiovascular disorders and their families have the right to know where they stand...

In-Hospital Cardiac Education Programs:

THE RIGHT TO KNOW

Carolyn Stockwe
Jeanette Tada



Simulated group session at St. Joseph's Hospital in Hamilton, including patients, family members, nurses and a doctor. Author Jeanette Tada is seated on the far left.

Health educators are just beginning to realize the problems involved in changing an adult's lifestyle. Preventive programs are well-intentioned and, in fact, statistics indicate that the mortality for heart diseases has declined by two percent — from 51 percent to 49 percent — in recent years.[1] But the fact remains that most people don't really listen until the lesson hits home — after the fact — and this is our usual point of contact.

The typical, coronary prone adult is usually confronted with the 'fait accompli' — he is an individual in crisis. He has developed symptoms that force him to present at an emergency room and later a coronary care unit — if he's lucky. Too many people die before hospitalization.

He has his first taste of hospitalization in an atmosphere of fear. His survival threatened, he finds himself in a strange world of wires, tubes, unfamiliar sounds, white-uniformed hustle and medical authority. Hospital nurses play an important part in his life at this point, ensuring that he survives life-threatening arrhythmias, that his pain and apprehension are relieved, and that his very basic, immediate "total needs" are recognized and met.

As the members of the health team in closest contact with the patient and the 'significant others' in his life during the acute phase of his illness, professional nurses have another obvious responsibility. From the moment our 'victim' enters the hospital door — he has the right to know what is happening to him. The question is, how, when and what do we tell him?

This article is a combined effort — it comes from two different settings and illustrates two approaches. Our intent is to demonstrate that the professional nurse, as part of a well-organized health team, can make the difference in cardiac rehabilitation and prevention of heart disease — whether she works in a small community hospital, a large university teaching hospital, in education, research, or community health. By sharing our experiences, we hope to be of some help to those who are in the process of setting up cardiac patient education programs. We make up only a part of the whole picture, and we acknowledge the value of many established programs throughout the country. With these programs, we share common goals: to educate cardiac patients and their families about the nature of the disease, to help them live productive lives, and to establish a positive emphasis on health.

As a *consumer* of health care, every individual has *learning needs*. As a *deliverer* of health care, every health worker has *educating responsibilities*.

St. Joseph's Hospital, Hamilton: *At the time of writing, the Cardiac Education Program of the Cardiac Unit at St. Joseph's Hospital, Hamilton, was not yet in operation. Target date — September 1976.*

The problem

WHY did this patient require another admission? What is he doing back in hospital? — he was just sent home! We *knew* our problem. Some patients just don't understand what it means to have a 'heart attack' — let alone a 'myocardial infarction'. Why didn't he take his medications? His doctor told him to rest! Why didn't he listen? What about his family? — surely they knew better.

The solution

A progressive hospital cardiac education program — that's what we wanted! As the patient and family progressed through his illness, we needed a program to ease the patient's transition from hospital to home, to prepare him for a new way of life, a lifestyle "focusing on prevention," and including the entire family.

Our program would be designed to:
- facilitate learning in individual and group sessions
- involve nurses, pharmacists, doctors, dietitians, physiotherapists and community health workers in the teaching process
- discuss and provide information on the nature, treatment and risk factors of heart disease
- evaluate the patient's understanding through follow-up to prevent another re-admission due to lack of compliance and understanding.

Perhaps the patient and his family appear to understand the instruction they have received in the hospital. But the patient is in a relatively dependent situation as long as he is hospitalized. His activity is restricted as a direct result of the hospital environment. How can we help him to be more responsible for looking after himself *before* he goes home?

Medication compliance is an important aspect of therapy for cardiac patients. Self administration of medications could be a significant aspect of increased independence for the patient. Once discharged, he is responsible for taking his medications; he must use his judgment as to when to call the doctor because of certain uncomfortable signs. We can help him to prepare for this responsibility.

Self-administration of medications is certainly not a new idea, and has proven a successful one. Some hospitalized patients can be educated in appropriate self-administration of prescribed medications prior to discharge. The patient is given responsibility for learning about his medications and for taking them in order to facilitate better compliance after discharge. This also allows nurses to evaluate the patient's understanding of his medications before he leaves the hospital.

Because a cardiac patient and his family struggle with an 'invisible disability,' we must take every step we can to help them visualize and understand....

Grace Hospital, Windsor: *Health teaching of cardiac patients and families has been operative at the Grace Hospital for approximately five years, with the support of physicians, nursing staff and allied health team members.*

With the ability to monitor individuals in practically any setting, it is important not to get caught up in gadgetry. People are attached to those gadgets and they need so much more than acute care. Perhaps we can prevent their readmission to hospital by teaching them about factors over which they can have control. Under the proper guidance and experience, we have the potential to teach as well as to provide care. At the Grace Hospital, our CCU staff presently teaches in both in-patient and out-patient settings.

There are important concepts to remember in teaching:
- the initial commitment of one human being helping another
- a solid knowledge of what you're trying to impart
- a united front — ie. different members of the health team teaching the same individual and his 'significant others' basically the same information — each knowing what the other has done via a written record
- honesty, tempered with a wisdom that comes from experience
- a sense of timing
- a sense of humor.

Teaching begins by active involvement of the patient in his own rehabilitative process.

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With confirmation of the initial diagnosis, the physician imparts basic information, reinforced by the nurse. Incidental learning is an integral part of nursing care, but our usual initial teaching approach is the one-to-one session.

Much has been written about 'nursing process.' Meaningful nursing process is simply credible, honest, and humane action. It is only common sense to get to know as much as possible about the individual patient, to respect him as a member of society, to assess what is really important to him, and to assist him to return to the mainstream as a productive individual.

This is what nursing conferences and nursing care plans are all about — the utilization of all the data and observations of the health team to realistically assess his progress. If you really know your patient, you will recognize his behavioral or verbal cues and his readiness to learn. Build on his basic knowledge of his situation, use specific heart foundation booklets to strengthen the effect of your teaching, clear up misconceptions, reinforce relevant information on his level. By being honest with yourself and with him, by using a positive helping approach, you encourage his independence and self-esteem.

Thus the patient's nursing care plan reflects your nursing management — it illustrates your approach and the patient's response to your teaching. When the patient is transferred from the progressive coronary unit to the medical unit, his transfer sheet gives a nurse-to-nurse written communication of his care and teaching in preparation for his discharge.

Recognition of the need for a more comprehensive cardiac follow-up led to the establishment of a pilot project in cooperation with the Public Education Committee of our local branch of the Ontario Heart Foundation, with post-hospital follow-up of MI and pacemaker patients by V.O.N. and/or public health nurses.

We are in the planning stages of defining nursing content for a common plan of care and

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teaching, with input from physicians and allied health professionals. Very valuable liaison has been achieved through regular visits of V.O.N. and public health liaison nurses in CCU. Exposure of the family group to a post-hospital support system and medical direction regarding the specifics of post-discharge care reflects the trend toward decreased hospitalization time, and more effective utilization of all health resources in our community.

Tuned to health

If we really care about health — we use all our professional skills and human talents to communicate to other human beings what's happened to them and how they can help themselves. What they do with that information is up to them — as adults they have the right to choose. A truly tuned-in health team uses all of its resources cooperatively and more efficiently to prevent costly hospital readmissions, improve quality of lifestyle and hence promote health rather than disease. This concept allows the individual to know where and when to tune in to a system that is ready and willing to accept him at any point in the spectrum of service which he contacts.

A truly enlightened health care team works together for the good of the patient without threat of overlapping roles. But the unsettling reality is that the job of health teaching often doesn't get done or gets deferred because of a human obstacle — obstinacy to change.

The layman is much too sophisticated to accept lack of answers for long. He is perpetually bombarded by all forms of media. And if he can't get answers from the people who should be giving them — the ones who really know his situation, then he will turn to other modes of obtaining the information he requires — and the advice 'for his own good' from nonprofessional sources may *not* be the best for his health. That's why the need to know and know from the right people is so important.

Nurses *can* help to prevent heart disease; we can minimize the risks of our own lifestyles and implement programs to educate and produce change....

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In 1975, she was named vice-chairman of the Canadian Council of Cardiovascular Nurses (CCCN). The Council, which is affiliated with the Canadian Heart Foundation was founded in 1973 to promote the quality of health care as it relates to cardiovascular function.

Convalescence following coronary surgery: A GROUP EXPERIENCE

Cécile Boisvert

The patient who has heart surgery and returns home will experience many problems in adjusting to a modified lifestyle. Successful rehabilitation depends on many factors — the knowledge the patient has about his condition, his own motivation and the support he receives from family and friends. If he has received good teaching in the hospital, his task will be much easier. But is in-hospital teaching enough?

Current nursing research suggests that patients are more receptive to health teaching *after* they have returned home and benefit from sharing experiences with a group. The author describes the results of an investigation into the concerns of convalescent coronary patients and their wives and tells how group sessions helped ease their transition from hospital to a productive lifestyle.

Several authors[1 2 3 4] have used group-therapy sessions to study the problems encountered by myocardial infarction patients and to help them adjust during the first year after the event. Until we began this study at the Institute of Cardiology in Montreal, however, no such study had been undertaken using aorto-coronary bypass patients as subjects. David[5] found that 38% of the coronary patients did not return to work even if the operation had achieved three major goals: relieved the angina, improved the myocardial flow and performance and returned them to a useful social life. Considering the lack of data with surgical patients, it was decided to do a pilot project to identify major problems during the convalescent period and to facilitate the reintegration of the patient to normal family and social life.

Method

Selection of subjects

The sample included only male patients who had had aorto-coronary bypass surgery during two consecutive weeks in January and who were residents of a metropolitan area. Six patients and their wives agreed to be participants in the study and to meet for 1 and 1/2 hours every other week, during the convalescent period, for a total of eight meetings. The group sessions were attended by a clinical nurse specialist and a social worker and were tape-recorded. Each taped session was analysed after the meeting by the investigators. Based upon Adsett's[3] experience, it was decided to start with a joint session, to have separate husband and wife groups afterwards and to conclude with both groups together.

Characteristics of participants

The ages of the six patients ranged from 37 to 56 years. Five of them were blue-collar workers. Considering the heterogeneity of the group in terms of age, socio-economic conditions and family problems, it would have been very difficult to have a control group.

The subjects presented these general characteristics: they were action-centered, had very little insight, presented type A behavior* including job involvement, speed and impatience, and were hard driving.

Role of the investigators

A modified non-directive technique was used by the clinical nurse specialist and the social worker. The fact that both investigators were women could have influenced the reactions of the group members, one way or another.

The following approaches were used:
— support and clarification;
—information and correction of erroneous notions or perceptions;
— frequent recalls of the contract i.e. the investigators had to remind the patients several times that they would not carry over information from one group to another;
— problem-solving for current difficulties experienced by the patient and his family;
— reinforcement of weak signals and assistance to express feelings associated with heart disease and the rehabilitation process.

Separate meetings were scheduled for participants who had personal problems not common to the group.

** Note: for information on type A behavior, see: Type A behavior and your heart by Meyer Friedman and Ray H. Rosenman, Knopf, 1974.*

Results

Patients' concerns

The themes changed gradually. At first, the subjects were mostly preoccupied with their health status but later became more restless and anxious to return to work. Most of them experienced psychological instability going from depression to euphoria and finally to a realistic outlook on their future. Analysis of the tapes permitted the investigators to identify eleven main concerns expressed during the group meetings.

Fatigue: Most patients experienced unexpected fatigue and a feeling of weakness after they left the hospital. They could not concentrate on minor tasks such as reading the newspapers or novels and their reaction was one of depression and/or irritability.

Pain: They became more sensitive to pain and more body-conscious. They were often afraid that their heart would beat too fast or too slow etc. ... Even if they were told before discharge that muscular pain would continue for a few weeks, they were surprised to be uncomfortable at home and hesitated to take their analgesics.

Sexual activities: Several patients expressed concern about resuming sexual intercourse especially because they were afraid to increase their heart rate or thought it might reopen or hurt the sternal incision.

Daily activities: Not being too sure of their own capacities, many patients wanted to know if they could resume certain activities. As for sexual activities, the more hesitant were helped by the experience of the audacious ones. One patient reported having walked four blocks, taken the subway and climbed four flights of stairs to go to the Insurance Bureau. At the next session, everybody reported more physical activities during the week.

Diet: This topic was very popular. Even if some expressed difficulties in adhering to a diet, it was considered as *the* magic solution and they were quite compulsive about it.

Risk factors: "Why did we get this disease? What are the causes?" Most of them attributed coronary disease to stress, work under pressure and high cholesterol. They had some doubts about the importance of cigarette-smoking. "My father died at 80 and he smoked more than a pack a day" or "There is so much pollution that a few cigarettes cannot change anything."

Work: This theme was mentioned at the first group meeting and was discussed regularly afterwards. There were mixed feelings about it such as fear and eagerness to go back to work. "I have worked too much, that's why I'm sick.", "My employer and co-workers will look at me as a walking-miracle." Some of them would have been ready to resume work after two months of convalescence but they were afraid to do so and did not have an appointment with their physician before the third month.

Euphoria: During the second month, there were expressions of euphoria. "I'm so happy to be alive and well that I catch myself singing when I drive my car."

Behavior: The group process permitted the participants to find ways to modify their attitudes and behavior such as:

- set more flexible deadlines;
- learn to take some time for hobbies and relaxation;
- learn to express and verbalize frustrations openly instead of keeping them inside.

Smoking: they found it very difficult to refrain from smoking and some were quite ambivalent about it. They frequently used rationalization. As a result, four out of six had resumed smoking after two months.

Family tensions: Many patients complained about their spouse's attitude. "She is too concerned about me" or "She won't let me do anything in the house." On the other hand, they were quite dependent at times. Bellak[6] explains this ambivalence, saying that the cardiac patient often projects onto his relatives "his own anxiety which stemmed from the underlying conflict over his unconscious wishes to be passive."

A radical change of behavior occurred in one patient. He was quite dependent on his wife before the operation and kept silent most of the time. During the convalescent period he became independent, talkative and showed a remarkable "joie de vivre." Consequently, the spouse who had previously assumed leadership and responsibility became very depressed and the family equilibrium was greatly endangered.

Wives' concerns

It was a wise decision to separate the groups because the wives did refrain from expressing their concerns and feelings in the presence of their husbands. This happened during both the joint-session at the beginning and at the end of the study period.

Activities: The wives were anxious about their husbands resuming physical activities. "Maybe he does too much," "he doesn't rest enough." They also expressed concern about sexual matters, being afraid of touching them or of hurting them some way.

Healing process: They wondered if there was a possibility that "he might have another infarct" and were afraid that "something can happen when he plays with the children."

Emotional conflict: The recurrent conflict between dependence-independence and irritable behavior of the patients upset them greatly. They did not know how to cope with the situation. "He wants to be left alone and he complains when I leave the house for a few hours."

Risk factors: Many questions were asked about risk factors and means to prevent recurrence of coronary disease. They felt especially responsible for preparing delectable meals to facilitate adherence to the low cholesterol diet. They were also frustrated to see their husbands cheating, either behind their back or when they received dinner guests. They had the same reaction when their husbands resumed smoking. "I felt as if the biggest building in the city had fallen on my head."

Wives complained of psychological fatigue after having been through the post-infarct period, the preoperative stress and the post-surgical convalescence. They needed information, support and understanding. Some of them had to face considerable financial difficulties and feared to share these responsibilities with their husbands. They felt the need to control their husbands, being responsible for them and somehow preventing them from having future heart trouble.

Group process

Patients' group

At first, the patients experienced difficulty in relating to each other and directed most of their comments to the investigators. They adopted a protective attitude toward each other and clearly bestowed special privileges on the youngest member of the group. They showed very little aggressive behavior and later, were able to use mutual support. Even the timid participants were able to express their views and offer valuable input to the group. As mentioned by Ibrahim[7], coronary patients are not inclined to introspection and these patients were somewhat resistant to exploring their own feelings.

Wives' group

Generally, the women were supportive toward each other and less centered on the therapists. They shared the leadership role alternately and expressed feelings or emotions more easily.

Considerations and conclusions

The pilot study was beneficial to both investigators and participants. It demonstrated the feasibility of designing a similar study on a larger scale, trying to control more variables. A multidisciplinary approach is worthwhile when health professionals can combine their respective skills and knowledge to attain a common objective. It became evident that the convalescent period is not as insignificant as it appears to the hospital staff and that people experiencing problems are very often left to their own initiative.

Analysis of the group discussion brought to light several positive results. These surgical patients had received verbal and written recommendations pertinent to diet, activity and medication before discharge. This teaching is done regularly by the head nurse or clinical specialist. However, we found that patients were more receptive to information *after* their return home. They clearly expressed the benefit of sharing experiences. Many reorganized their daily activities and modified their type A behavior. None of them used tranquilizers or sleeping pills at the time of the last meeting. There was good compliance to the medical regime and one overweight patient even lost 20 pounds. All six patients returned to work; one patient, aged 55, changed his job. The wives left more responsibility to their husbands and most of them resumed their role in the family unit.

In conclusion, we feel that important patient and family problems were identified and that nurses working with cardiovascular patients can use these indices to prevent complications and facilitate rehabilitation.

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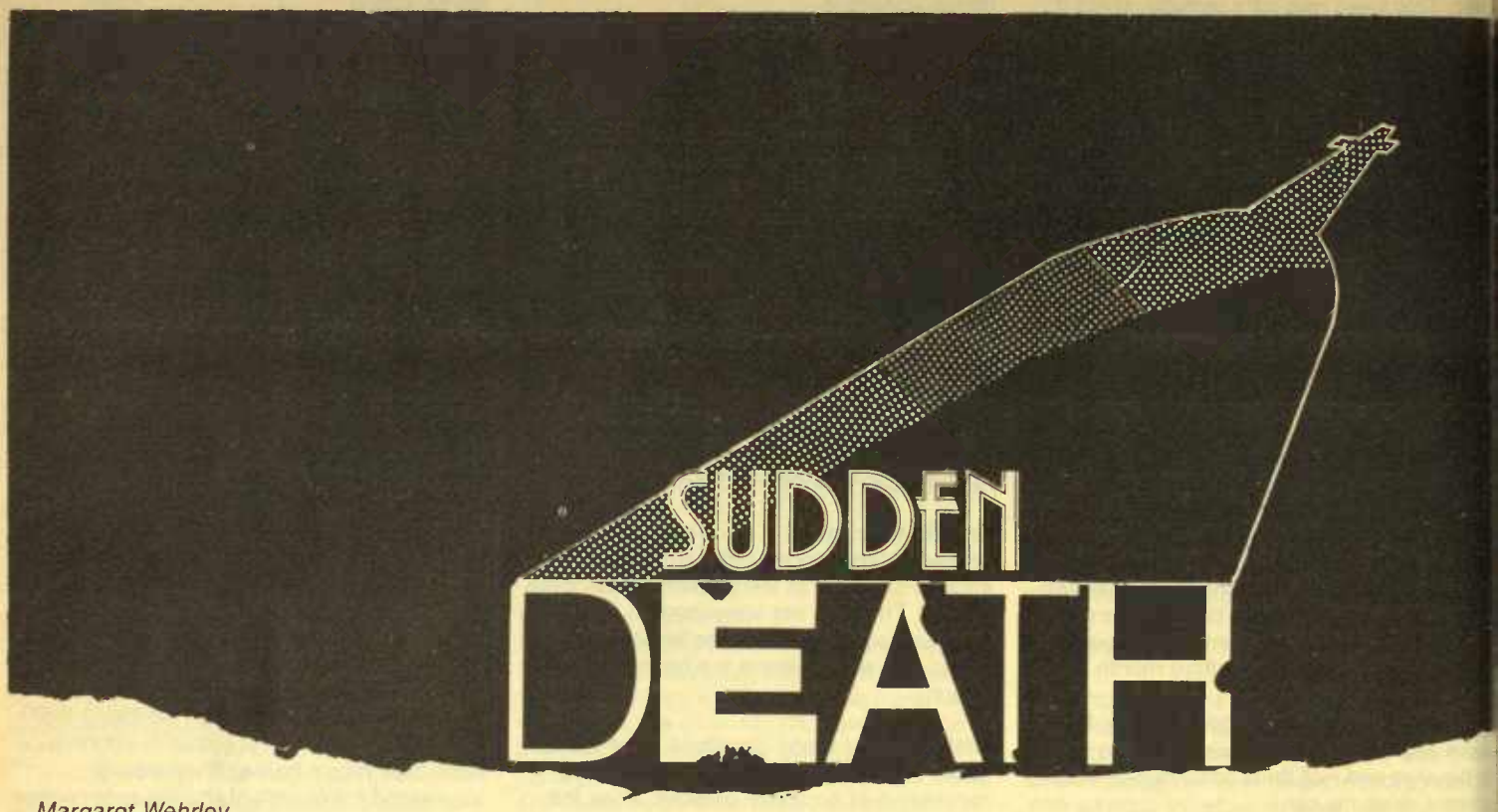
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Margaret Wehrley

The threat of sudden death due to a myocardial infarct inevitably places a severe strain on the patient, who may realize the severity of his condition, on the family who are justifiably concerned about the life threatening situation the patient is in, and on the coronary care nurse who is involved in his care. Each one reacts to this stress in his own way. If the nurse can begin to understand her own reactions and the reactions of the family and patient, she will be better equipped to help them cope with this crisis situation.

The Family

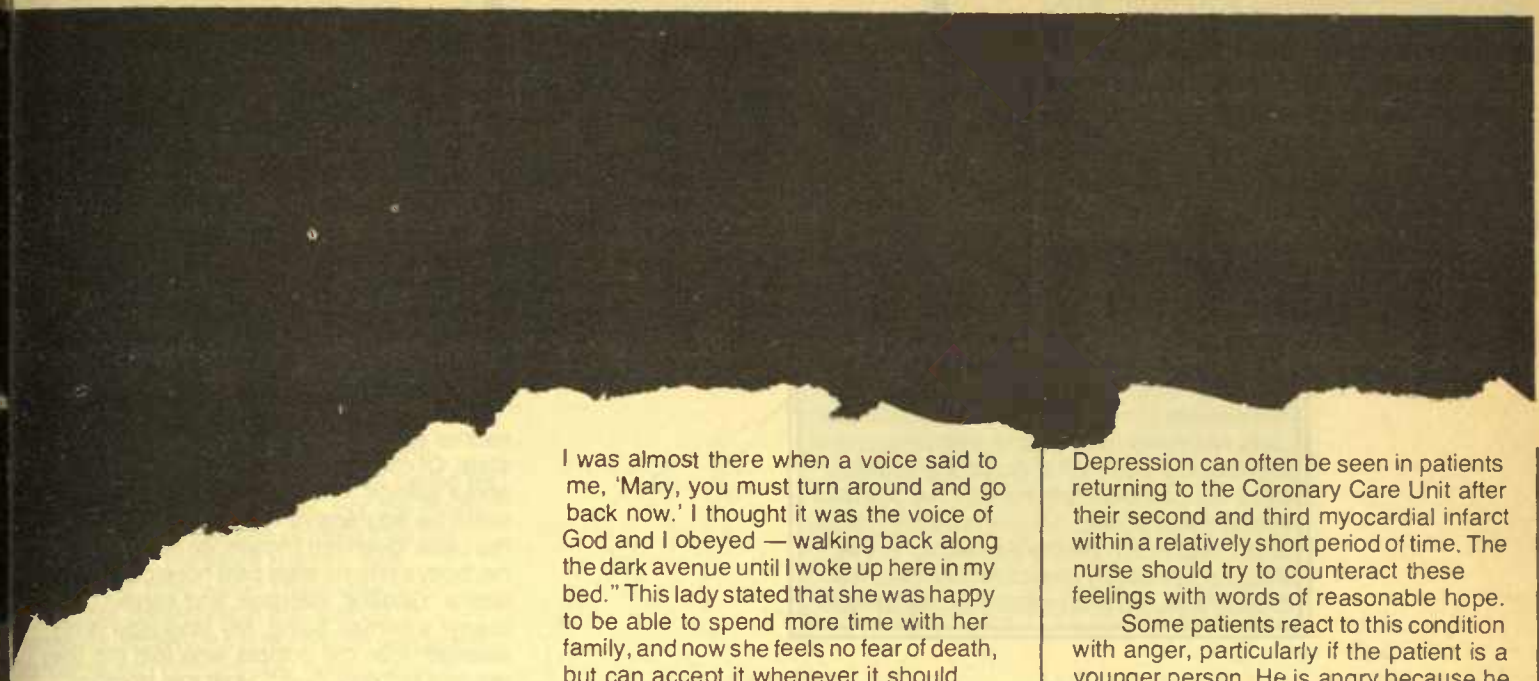
Sudden illness or death from a myocardial infarct causes intense shock to the relatives who have no opportunity to prepare themselves for such a change. Very often, the last time the family saw the patient, he was well, perhaps leaving the house for work. They are summoned to the Coronary Care Unit to find him critically ill, attached to various machines and other unfamiliar devices. Most relatives are not able to listen to detailed explanations at this early stage — they want reassurance that the patient will survive this crisis.

In the CCU, during the first critical hours, the nurse's energies are directed towards the care of the patient, but the family, also, needs a great deal of support. Relatives require simple, concise and personal explanations about the patient's condition and his care. [Often, fear of the equipment in the CCU keeps relatives from coming close to the patient. A simple explanation of unit equipment by the nurse may alleviate some fears and she can let them know that it is alright to touch the patient.]

If sudden death occurs due to cardiac arrest, resuscitative measures prohibit the family from being at the bedside at the time of death. A family's reactions to such a sudden loss are usually intense: they include grief, anger, despair and disbelief. The nurse who has studied the patient and that particular family's reaction to illness, can offer valuable support during this crisis.

The Nurse in CCU

The Coronary Care Nurse acts as a mediator between patient and family, answering questions, facilitating their expressions of fear and supporting them in their sorrow. She is also closely involved with her patient. This involvement is sometimes difficult but it is always essential. From the time he arrives on the Unit, the patient depends heavily on her support. Like his family, the nurse feels anxiety and fear when the patient has a sudden cardiac arrest, but this anxiety can be transferred into the energy necessary to deal with the situation. She is geared towards the prevention of sudden death in the Unit and therefore tends to think of death as a failure on her part. Rather than thinking "Could the health team have done anything differently?" — she may think "What did I do wrong?" — What did I miss?' The most difficult hurdle the nurse in CCU must cross is acceptance of a patient's irreversible diagnosis or unsuccessful resuscitation.



The Patient Who Survives A Cardiac Arrest

If the patient realizes what has happened to him, it becomes vitally important that he be encouraged to communicate his thoughts and anxieties regarding this event. The nurse in CCU is in a unique position, because of her constant presence, to invite the patient to express his concerns freely. Having suffered one cardiac arrest, he must live with the possibility of another. Anxiety is the normal reaction and research has shown that it can place as much strain on the cardiovascular system as does exercise. Unalleviated anxiety, can lead to depression, and together these two emotions can cause a mental and physical deterioration. This condition has been named "The Lazarus Syndrome."

Acceptance of cardiac arrest varies from one individual to another. The following examples of patients in our CCU who have survived a cardiac arrest and their reactions to it, illustrate these differences.

- An elderly lady was in the Coronary Care Unit for a second time. She suffered a cardiac arrest and was successfully resuscitated. On recovering and realizing what had happened, she was able to give this description of her "death." "I was walking down a long avenue; it was very dark, but I kept walking because I could see, at the end, a beautiful purple haze. I knew instinctively that there was peace and happiness there, so I kept on walking. I was almost there when a voice said to me, 'Mary, you must turn around and go back now.' I thought it was the voice of God and I obeyed — walking back along the dark avenue until I woke up here in my bed." This lady stated that she was happy to be able to spend more time with her family, and now she feels no fear of death, but can accept it whenever it should occur.
- A 42-year-old school teacher suffered a cardiac arrest while he slept. He was quickly defibrillated and continued to sleep until morning. On being told of the occurrence by the patient in the next bed, he flew into a rage shouting "What right do you have to interfere in my life?" Perhaps anger was his way of expressing his fears.
- A middle-aged man who had been the executive director of a large company was involved in city council and service club work. Following his cardiac arrest and resuscitation, he became depressed and fearful, refusing to become involved in any kind of rehabilitation program. He stayed at home worrying about his future, his disease, his next chest pain. He had repeated admissions to hospital, each causing more anxiety but no further heart damage. Finally, he died — an example of "The Lazarus Syndrome."

The majority of patient's psychological reactions fall between examples one and three. Many people have a feeling of impending death in the early hours following myocardial infarction, but for the majority, their condition stabilizes and death does not occur. However, the patient often remembers this feeling and emotions of loneliness, depression, anger or denial may follow as he improves physically. The nurse may notice her patient is quiet and withdrawn. Although he is surrounded by hospital personnel, he feels lonely — perhaps because of the unfamiliar surroundings which prohibit or restrict activities of daily living and contact with family members. Statements such as "I am just another piece of machinery," or "You treat me like a child," or "I am no use any more" should alert the nurse that her patient is developing feelings of loneliness and depersonalization.

Depression can often be seen in patients returning to the Coronary Care Unit after their second and third myocardial infarct within a relatively short period of time. The nurse should try to counteract these feelings with words of reasonable hope.

Some patients react to this condition with anger, particularly if the patient is a younger person. He is angry because he feels this illness will interfere with his life plan, perhaps jeopardize his future. He may direct his anger towards the nurse or the doctor, but usually it is towards the one he cares for most — his wife or a close friend.

Other patients may appear jovial, joking with the staff and doing more than their activity program allows. One may feel that a patient who behaves in this way has accepted his condition, but the "happy-go-lucky" air is sometimes a front to hide the anxieties inside. This behavior may be a form of denial because he is not able to face up to the situation at this time.

Conclusion

Excellence in nursing in the Coronary Unit is not measured by the number of medical responsibilities a nurse is allowed to assume but, rather, by her willingness and ability to invest in supporting emotional as well as physical adaptation to stress.

Margaret Wehrley, the author of "Sudden Death" has been Head Nurse in the Coronary Care Unit of Plummer Memorial Public Hospital in Sault Ste. Marie, Ontario, for just over eight years. Her motivation in writing the article came from a desire "to share some of this experience with other members of the profession".

A graduate of Leicester Infirmary in England, Wehrley has also worked at St. Catharines General and Kitchener-Waterloo Hospitals.

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to whom it may

Catherine Winter

Last Spring my mother died. In a sense it was a victory for her, and because the situation surrounding her death was unusual, I promised the hospital's patient representative to describe our experience in the hope that it will provide some insight into the relationship between dying patients and their families and the medical staff. What made my mother's case unusual was not the fact that she was resuscitated against her will, but that my sister and I seemed to be the first family at that hospital to actively object to maintenance procedures and to take action on her behalf ...

You would have to have known my mother to appreciate the circumstances of the case. She was a gutsy, independent lady, a registered nurse, class of '26. Her working experience was comprehensive. She had a congenital back deformity that was a source of intermittent (though it often seemed constant) pain. She did not complain often. She was privately religious. She had a mercurial temperament, a wide range of interesting friends, the desire to look after others and take care of herself. She was widowed for eight years and while she didn't express bitterness at the loss of my father, she must have missed him a great deal. He had been the victim of a tragic accident in 1959 and after numerous stays in hospital and five major operations, recovered to the point where he could drive a car and play a little golf. He bore his suffering stoically: he said he felt it was worth the fight to live when he first regained consciousness and realized his brain was undamaged. The only time we heard him complain was when he was served a piece of "shoe leather" roast beef for his first solid meal after three weeks of IV's!

In 1968, my father had two or three massive strokes in one day and then died. My mother was grateful that he was spared the ordeal of a lingering death. After he died, at various times that were *not* stressful, members of the family talked about our feelings and desires. What emerged was a pattern of opinion on the quality versus the quantity of life. Mother in particular expressed the hope that when the time came, she would die quickly. She asked us to protect her from the use of heroic measures to prolong her life. She feared dependence on others and pain. She wanted only to be an a*ctive* individual. In retrospect, I think Mother knew how sick she was. This is why she resisted going to hospital and gave such inaccurate verbal histories. I think she was terrified of the treatment she would have to submit to; at one point she said she would never have open-heart surgery.

Mother entered hospital early one morning. During the next five days, she was moved to seven different rooms. Then, on the fifth night, she had a cardiac arrest. She was placed on a respirator and never became conscious again. At about noon the next day (my memory of exact times becomes hazy) we began to communicate mother's desire not to be kept alive by extraordinary measures. What follows is an account of what happened after that, without naming individual doctors or attempting to reproduce specific conversations with each medical staff member we approached for help. With one notable exception, we found the nursing staff to be totally compassionate and sympathetic to us as well as utterly competent in carrying out their professional duties.

The evening of her cardiac arrest, Mother's doctor telephoned me at home to say that her condition was so bad that she would be better to die. Probably at his insistence, the cardiac unit chief confirmed the hopelessness of Mother's condition early the next afternoon. All the residents gave us the "element of hope" routine, saying the chances were she wouldn't die and could go home, basing their judgment on her initially favorable response to resuscitation. One said, "Wouldn't you like to have her back if you could?" This particular resident seemed to appreciate our feelings at the outset. He said he wished he'd known Mother's wishes before he resuscitated her but after this was effected, he could not withdraw mechanical and chemical aids. Another commented: "She isn't suffering, and if she regains consciousness, she won't remember." One even used a frog with its head cut off as an example of reflex action to demonstrate response in the absence of pain. I felt this was in poor taste and was an unsupportable scientific analogy to draw in Mother's case. This man also hid behind a .0001% statistic of chance of recovery. In another context, he said that the cardiac unit was not "machine oriented" and that there was much more elaborate equipment that could be mobilized in an intensive care unit. If that is so, what justification was there for a halfway approach?

One doctor said he had not heard my mother express a death wish in her conscious state. Of course he hadn't. We are not talking about suicide. I feel that the initial refusal to withdraw aggressive life support measures *in this case*, given the knowledge that so many of her body systems were past hope of recovery, was a "Godlike" decision, and served only to martyr a human being. My language is no stronger than the doctors who told me they refused to "play God." How can doctors identify themselves with murderers or executioners because they remove life support measures when the process of dying was initiated *before* they interrupted and arrested it?

Argument on a philosophical plane seems to lead to a stalemate. In our case, the patient and the family lost (temporarily). Would a more businesslike approach have been better? Can health care be considered a service that may be cancelled at any time by the patient or his family? What legal rights does a person give up when he enters hospital? The patient and family have no power in a hospital setting unless they are fully aware of whatever rights exist and they can only be advised of these by legal or hospital personnel who are sympathetic to them and willing to assist them. In our case, a nurse directed us to the patient representative whose intelligent handling of our situation was invaluable to us. The balance of power resides with the doctors who supposedly view each case objectively. They have the power to divulge or not to divulge knowledge of a patient's condition, the power of that knowledge and its attendant aura of expertise, the power to act and then inform or not inform the family and patient. The tendency of some doctors to close ranks with their colleagues reinforces all these other powers.

I understand that patients who are physically able may leave hospital by signing a form stating that their departure is without their doctor's approval. How many patients are aware of this situation? Is there such a thing as a patient's bill of rights? Who makes this information available? Who counsels patients when they sign hospital consent forms? Do they always know the full import?

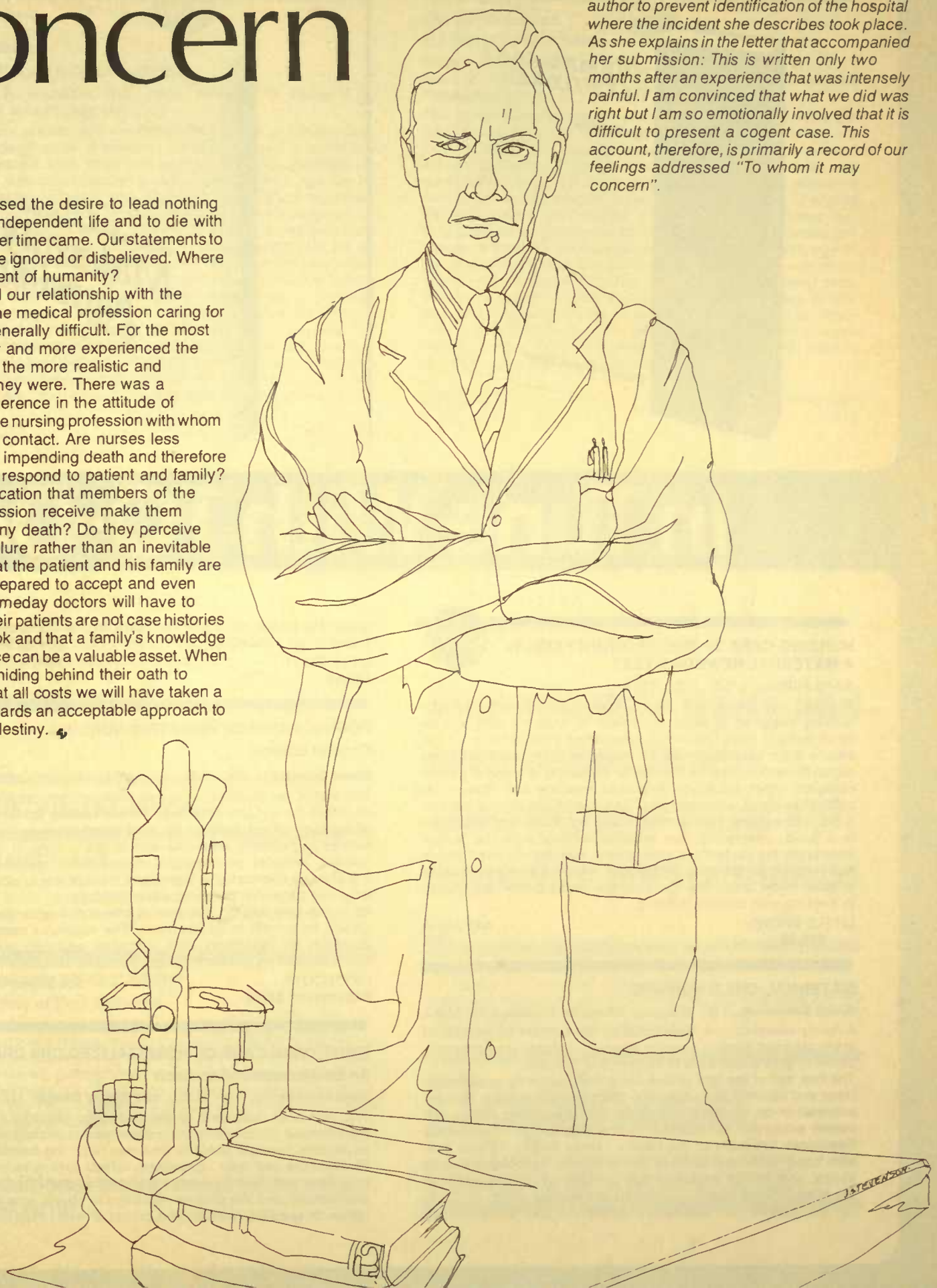
The rights and wishes of the patient must be the so*le* concern of the family and of those who provide health care. These rights can only be protected if each case is considered on its own merits. In our case, the patient was a seventy-year-old grandmother who had

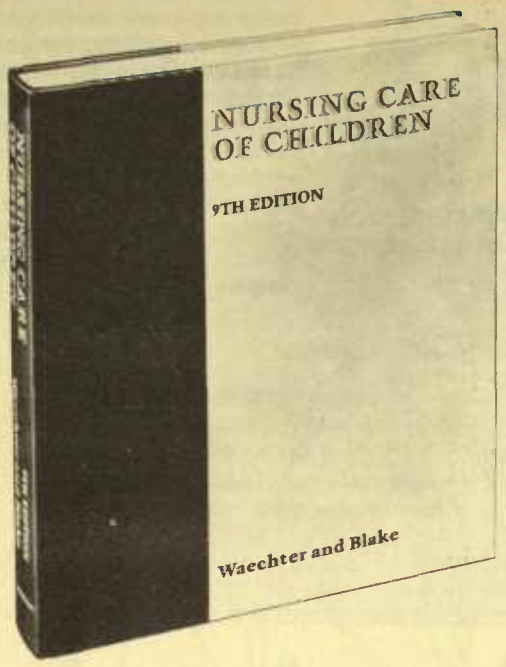
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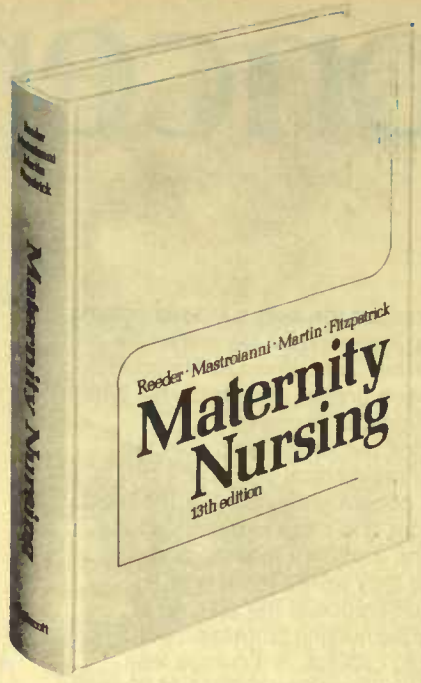
Catherine Winter is a pseudonym used by the author to prevent identification of the hospital where the incident she describes took place. As she explains in the letter that accompanied her submission: This is written only two months after an experience that was intensely painful. I am convinced that what we did was right but I am so emotionally involved that it is difficult to present a cogent case. This account, therefore, is primarily a record of our feelings addressed "To whom it may concern".

clearly expressed the desire to lead nothing less than an independent life and to die with dignity when her time came. Our statements to this effect were ignored or disbelieved. Where was the element of humanity?

We found our relationship with the members of the medical profession caring for our mother generally difficult. For the most part, the older and more experienced the doctors were, the more realistic and sympathetic they were. There was a noticeable difference in the attitude of members of the nursing profession with whom we came into contact. Are nurses less threatened by impending death and therefore better able to respond to patient and family? Does the education that members of the medical profession receive make them anxious to deny death? Do they perceive death as a failure rather than an inevitable happening that the patient and his family are sometimes prepared to accept and even welcome? Someday doctors will have to accept that their patients are not case histories from a textbook and that a family's knowledge and experience can be a valuable asset. When doctors stop hiding behind their oath to preserve life at all costs we will have taken a giant step towards an acceptable approach to our ultimate destiny.







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EMERGENCY CARE OF THE ACUTE MI

Lise Viau Gauthier
Michèle Simoneau

In Canada, 50,559 people died of heart attacks in 1973. The swift administration of emergency medical treatment is the key factor in increasing the MI patient's chance of survival. The patient with chest pain must be considered the number one priority if mortality rates for acute myocardial infarction are to decline.

Subjective symptoms of the patient

The most common subjective symptom of an acute MI is pain. The patient may describe the pain as:

- tightness in the chest
- pressing, crushing, viselike
- radiating down arms (most often the left) and into fingers causing numbness
- radiating up the neck and into the jaw
- having a sudden onset
- constant and not relieved by nitroglycerine or by change in position
- may compare it to indigestion or gallbladder attack.

Objective observation by the nurse

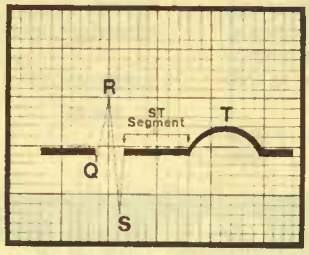
Look at the patient.
Does he exhibit the following signs and symptoms:

- diaphoresis?
- pallor?
- cold, clammy skin?
- labored and rapid breathing?
- cyanosis especially around lips, nail beds and ear lobes?
- nausea and vomiting?
- anxiousness and restlessness?
- altered vital signs
  - — lowered BP?
  - — tachycardia or bradycardia?
  - — apical pulse irregular in rate and rhythm indicative of arrhythmias?

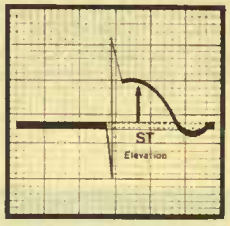
Emergency Management

1. Give O_2 to the patient at 4-5 l/min by mask and place in semi-Fowler's position if not already sitting up.
2. Start an intravenous (usually 5% DW) to keep the vein open.
3. Apply chest leads, attach patient to a cardiac monitor and take a twelve-lead ECG. Observe ECG tracing and check the S-T segment. If the S-T segment is elevated, this signifies injury to the myocardium. If the S-T segment is depressed, this signifies ischemia. Ischemia will also be indicated if the T wave is inverted. A deepened Q wave on the tracing indicates that the myocardium has suffered necrosis several days prior (see Figure 1).

Figure 1



Normal PQRS tracing



S-T elevation indicating recent injury to the myocardium

Figure 2

Enzyme Blood Levels Following MI[2]

Enzymes	*Normals*	*Blood level peak*	*Return to normal*
SGOT	7-40mU/ml	1-2 days	4-6 days
LDH	Up to 288mU/ml	2-3 days	7-10 days
CPK	0-94 mU/ml	6-24 hours	2-3 days

4. Relieve severe pain and anxiety. (Usually Demerol 75-100 mgm or morphine 10-15 mgm I.M. will be ordered by the doctor). Give intelligent explanations and reassurance to the patient.
5. Take blood samples for CBC, electrolytes and cardiac enzymes (see Figure 2). Blood gases should be taken if the patient is having very labored respirations (see Figure 3).
6. Be alert for developing complications:

- ***cardiac arrhythmias***

Have a bolus of Xylocaine 100 mgm and a Xylocaine drip 1mg/500 ml* readily available for the treatment of PVC's (premature ventricular contractions) and ventricular tachycardia.
Pacemakers should be readily available in the event of bradycardia and complete heart block.

- ***CHF (congestive heart failure)***
- ***cardiogenic shock***

The mortality rate associated with this complication is reported to be as high as 80%.[1]
Signs and Symptoms: hypotension, oliguria, cyanosis, restlessness, apathy, metabolic acidosis. Central venous pressure (CVP) equipment should be on hand for insertion if necessary.

- ***left ventricular rupture***
- ***cardiac arrest***

* Dosage used at Ottawa General Hospital, Ottawa, Ont.

Figure 3*

Blood Gas Analysis

pH	7.35-7.45
H mEq/1	45-35
PCO_2 mmHg	35-45
HCO_3 mEq/1	22-26
PO_2 mmHg	80±15
O_2 Sat.%	> 95

* Normal values at Ottawa General Hospital

CHEST PAIN

....a summary

Lynda Parks

When a person enters the Emergency Department and states that he is experiencing chest pain, what is your reaction? How do you evaluate his complaint? What knowledge do you utilize in making a nursing assessment?

The purpose of this short text is to aid you in your evaluation of chest pain as a symptom of many varied conditions. Hopefully this summary will provide a basis for making intelligent decisions regarding the severity of the condition and about the kind of emergency care you will provide.

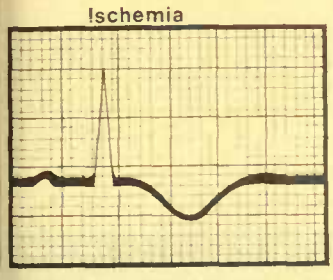
Pain is a subjective symptom. What the patient can tell you about his chest pain, how he describes it, can be the key to diagnosis. Often, we miss pertinent information due to poor interviewing and questioning skills. In communicating with patients, try to speak within their frame of reference and understand that their interpretation of the pain is influenced by past experiences, conditioning to pain, culture, age, sex, and emotional stability.

Systemic evaluation of the chest pain according to character, location, onset, duration and associated symptoms gives us a more complete picture and allows for a more thorough nursing assessment of the possible causes of the pain. This can then be related to other members of the health team as a concise informative history of the current episode so that prompt treatment is instituted.

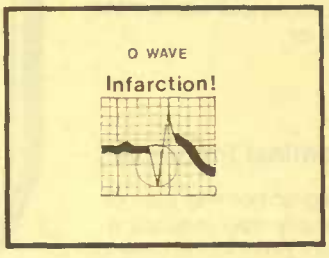
Let us now review chest pain as a symptom and discuss the various diseases or problems in which chest pain is a complaint. True cardiac pain will be dealt with first.

Pain from Mediastinal Structures

- ***Angina pectoris*** is paroxysmal pain due to myocardial ischemia. The patient may describe it as a tightness, heaviness or a weight on the chest. Or, it may be burning, gripping, stabbing, crushing or squeezing. A familiar picture is the individual with a clenched fist on his chest. The location is generally substernal, precordial or widely diffused throughout the upper chest. This pain frequently radiates to the left pectoral area and down the medial aspect of the arm continuing to the ulnar aspect of the hand. Radiation may also occur to the neck, jaw, temporomandibular joint, scapular area, and occasionally to the epigastrium and may mimic indigestion. Onset is sudden, usually on exertion, emotional excitement, eating a heavy meal, sexual intercourse or mental stress. It is mild to severe in intensity lasting 3 to 5 minutes and is relieved by rest and/or nitroglycerine. If anginal pain lasts more than one half hour, suspect an impending myocardial infarction.
- ***Myocardial infarction*** pain has the same location, radiation and quality as angina pectoris. The differences are:
— infarct pain can be unrelated to exertion or stress and may wake the person from sleep.
— it is a constant severe pain unrelieved by rest, nitroglycerine and other remedies.



T wave inversion indicating ischemia



Deepened Q wave indicating necrosis

Diagnosis of an acute MI is usually based on:

- **patient history**
- **ECG changes**
- **cardiac enzyme elevation**

Remember, the nurse must be cautious in her evaluation of the patient with chest pain. Some MI patients have very few symptoms and no ECG changes. They may be admitted to hospital solely on the basis of a patient history for observation.

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About the authors:

Information contained in Emergency Care of the Acute MI *is made available to readers with the cooperation and assistance of two nurses presently working at the Ottawa General Hospital.*

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With this extreme pain, diaphoresis, hypotension, cyanosis, labored respirations, nausea and vomiting often occur. Pain due to myocardial infarction is relieved only by narcotics.

- The pain of ***pericarditis*** arises from the irritation it causes to adjacent structures. The friction rub may be heard with a stethoscope as a scratchy, grating or creaking sound. The pain can be deep, constant and substernal or superficial on the chest wall. Some patients describe it as knifelike or shooting. Deep breathing, laughing or coughing intensifies the pain and relief may occur by leaning forward. If the diaphragm is irritated, the patient experiences shoulder or neck pain.
- ***A dissecting aortic aneurysm*** produces a sudden, excruciating, sharp, crushing or tearing substernal pain. The pain is experienced as blood collects between the layers of the blood vessel wall or because the enlarged aorta exerts pressure on adjacent organs. The pain diffuses over the upper anterior chest and into the shoulders, base of the neck and back. The patient is usually restless and unable to attain a comfortable position. A difference between the carotid and brachial pulses exists when dissection prevents blood flow to carotid arteries but allows flow to brachial arteries.

Chestwall Pain

- ***Intercostal nerve pain*** from irritation of the nerve may produce sudden pain of variable quality. Local tenderness in the intercostal space may be present. The pain experienced in Herpes Zoster is one example of intercostal neuritis.
- Pain from ***slipping rib cartilages*** is dull and located over the costochondral junctions. Tenderness is felt on light pressure. This pain may exist for long periods of time and the location and chronicity of it help in establishing the diagnosis.
- ***Pectoralis minor myositis,*** a muscle inflammatory process, can produce severe anterior chest pain that may resemble cardiac pain if present on the left side.
- ***Bone pain*** (ostalgia) from any cause may produce either generalized or localized chest pain. Spinal disease causing inflammatory processes or mechanical irritation may produce sharp, stabbing or dull back pain referred to the anterior and lateral chest wall and arms. This referred pain may resemble angina pectoris but is usually associated with back pain and related to movement of the thorax.

Pain Arising from Respiratory Structures

Anterior cervical or retrosternal pain can be produced from acute inflammation of the tracheobronchial tree. Generally, it is accentuated by coughing.

- With ***pleurisy or pleuritis*** the patient experiences localized knifelike, shooting pain adjacent to the area of inflammation. Pleurisy may cause spasm of the intercostal muscles producing superficial chest pain. The pain may be accentuated by breathing, laughing or coughing. Relief is obtained by holding one's breath during deep expiration and by splinting the chest. The patient often assumes an awkward position in order to obtain relief. If the onset of pleuritic chest pain is sudden and accompanied by a marked shortness of breath and decreased air entry, a ***pneumothorax*** must be suspected and promptly investigated.
- ***Pulmonary embolus*** may or may not be associated with pain. If present, it is a deep, crushing or knifelike, shooting pain reaching maximum intensity substernally. The pain increases on inspiration, differentiating it from cardiac pain. The patient may be apprehensive and express a feeling of impending doom. To assess this pain look for predisposing factors such as calf tenderness, immobility, dehydration or hemoconcentration.

Pain from Abdominal Problems

- Steady, dull, gnawing or burning pain of slight to moderate intensity may indicate a ***peptic ulcer.*** The patient can often predict its occurrence in relation to meals (generally 3 to 5 hours after eating). It is relieved in 5 to 15 minutes after taking antacids. The pain may be a generalized abdominal pain or epigastric pain and may radiate to the shoulders. Esophageal pain may increase with swallowing and is frequently associated with gaseous eructations and regurgitation. The pain can be referred to either the sternum or posterior chest. *If a patient complains of "heartburn", it is important to decide whether this is due to gastrointestinal or cardiac involvement.*
- ***Gallbladder pain*** is diffuse epigastric or right upper quadrant pain and may radiate to the right shoulder or back below the right scapula. Accompanying this pain is restlessness, pallor, sweating, fever, vomiting and abdominal wall tenderness. When caused by gallstones, the onset of pain is sudden, severe and reaches its maximum intensity in 5 to 15 minutes.

On the basis of the preceding information, you can question the patient who arrives in Emergency about his chest pain and either confirm or rule out a cardiac component. The details you gather from the patient about his pain can be utilized to assist you in determining the appropriate course of action. If you are in doubt as to whether or not the pain is cardiac, *always* place him on a monitor until the physician can make a detailed assessment.

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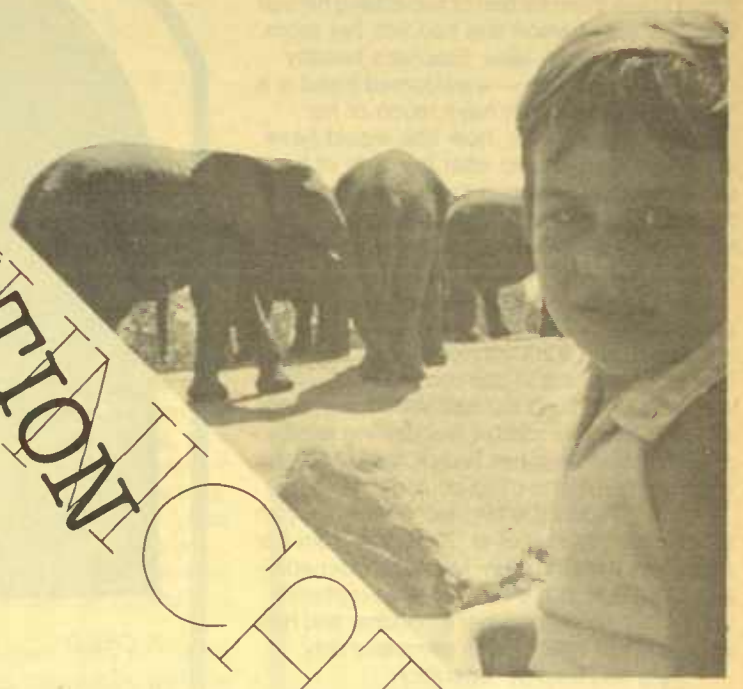
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COMMUNICATION OPERATION



Sharon Bala

Five-year-old Stephanie had arrived in Emergency with what her mother thought was an attack of appendicitis. After careful examination by her pediatrician, however, she was diagnosed as having "Periodic Syndrome," a psychologically triggered condition.[1] *The following is an account of her mother's efforts to improve communication with her daughter and to help relieve the stresses that had caused her psychosomatic condition.*

When Stephanie was diagnosed as having a psychosomatic illness, I had to realize that it had been building up for a long time. She did not change from a healthy, normal five-year-old to a child suffering from such severe emotional stress overnight. In fact, when I analyzed it, I realized that Stephie's problems dated back to her second year.

Three years before she was taken to the hospital, Stephie had her first encounter with the emotional pain of death when her "grampa" died. That in itself was not enough to trigger her condition, but the events that followed were.

One month later, and only a few days before Christmas, her father and I separated. A Christmas without "daddy" little Stephie did not understand, and efforts to make her happy with impressive presents failed. No one could mend her broken heart. No longer would she stand patiently at the living room window of her father's home waiting for his return from work to run into his open arms and share a mutual love and admiration.

Mommy and daddy didn't like each other anymore, and what about Stephanie? Did she blame herself? Losing her father was beyond her comprehension; yet, I was too drained of energy and all emotions except self-pity, to see how devastating this event was for my daughter.

Five months passed and it took five moves, complete with bag and baggage, before Stephie's broken family (consisting of herself, her pregnant mother and her chronically ill one-year-old brother) finally settled in a suitable and comfortable home. Physically she lived there but her heart remained in a place she once called home with a man she once called daddy.

She found it difficult to accept that he could not stay with her after their day in a week together. Those special days became scarce, then non-existent, and Stephie's nightmares began to occur more frequently. Still, the message they conveyed continued to go unheeded; I was too busy caring for Ali, whose hydrocephalic condition and accompanying epilepsy demanded constant care. His seizures frightened Stephie, and when her brother cried she cried even harder. *Perhaps she felt afraid for Ali and anxious herself because she couldn't understand his condition.* I heard Stephie's cry, but not the feeling it expressed; I was still too deeply engrossed in my own hurt to be objective and receptive to Stephie's.

Through the months that followed, Stephie's life remained in a turmoil; her father didn't visit her anymore, Ali was in and out of the hospital, and then one day he didn't come home at all. He was in an institution. *What is an institution? Doesn't mommy love him anymore? What about me?* These questions perhaps plagued her mind but she felt too

afraid to ask them for fear of separating herself from the only person she had left, her mom.

A few months later, Stephie's healthy baby sister was born — a welcomed friend or a threat? *Stephie didn't have much of her mom's time as it was, now she would have even less.* One month after the birth of her sister, Stephie attended the funeral of her brother. She began to withdraw into herself, lost in the midst of her confusion, all her efforts to express herself unattended.

Physically she had been adequately provided for but her emotional needs were intangible, and went unheeded until the day I found her writhing in pain on the floor. No, it was not appendicitis as I had feared, but rather a lack of communication manifesting itself psychosomatically, her body's way of saying what her heart and mind couldn't — I hurt.

Thus, "operation communication" began as an attempt to recover Stephanie from her alienation. It wasn't easy. Most was learned by trial and error. But it has helped Stephanie cope with and express her emotions, and has improved our relationship immeasurably.

As a first step in "operation communication" I attempted to learn more about myself, to become more objective and more accepting of my "faults," and to give myself a break by "accentuating the positive." I felt I had to rekindle my own self-confidence before I could do the same for Stephanie.

In my relations with Stephanie, I began to adopt a few changes in an attempt to become more receptive to her emotional needs. I learned to rearrange my priorities and postpone my own needs, when appropriate, to listen to Stephie. Gradually, she became less apprehensive about approaching me as she grew to know she wouldn't always hear, "Not now, I'm busy."

I had to learn how to really listen, not only to the *content* or superficial meaning of what Stephie was saying but also to the *intent* or underlying message. To do this I had to learn to look at things from Stephie's point of view and begin talking *with* her instead of *to* her.

We also practiced expressing our feelings in ways more acceptable to society.[2] Good feelings we called "warm fuzzies;" bad feelings were "cold pricklies." We learned to release hostile feelings by "punching a pillow." The focus was on getting the feeling out, not keeping it bottled up inside as Stephie had done in the past, or projecting it as I had done by yelling at Stephie. Soon, it wasn't uncommon for either one of us to stop what we were doing to say "I love you" to the other, regardless of the time or place.

After we had vented our pent up feelings, we would try together to tackle the problem or cause. We would explore possible solutions and see which helped. We tried not to tell each other what to do because that never worked and only got "dander up" again.

When Stephie wanted to talk we would try to find a quiet place where we could be





A CHILD

If a child lives with criticsm,
he learns to condemn.
If a child lives with hostility,
he learns to fight.
If a child lives with fear,
he learns to be apprehensive.
If a child lives with pity,
he learns to feel sorry for himself.
If a child lives with jealousy,
he learns to envy.
If a child lives with encouragement,
he learns to be confident.
If a child lives with tolerance,
he learns to be patient.
If a child lives with praise,
he learns to be appreciative.
If a child lives with acceptance,
he learns to love.
If a child lives with approval,
he learns to like himself.
If a child lives with recognition,
he learns it is good to have a goal.
If a child lives with fairness,
he learns what justice is.
If a child lives with honesty,
he learns what truth is.
If a child lives with security,
he learns to have faith in himself
and those about him.
If a child lives with friendliness,
he learns the world is a nice place
in which to live.
If you are the parent,
with what is your child living?

Author unknown

A child's education is principally derived from its observations of the words and actions of those with whom it lives — the situations with which it comes in customary or repeated contact.



physically close to do so. Often just before bed we would take time for a "little lovin" and a "little communication," and afterwards I would hug Stephie, conveying through gentle touch how much I cared.

Stephie conversed at her own speed during these special times, and I tried to stay on the same wave length by being objective and looking at things from Stephie's point of view. Empathy and authority somehow did not mix. One had to go, so during these sessions I became a non-judgemental "sounding board."

"Because I said so" was no longer given as a reason without an explanation. I had heard it often enough when I was young and remembered how utterly frustrated it made me feel because it told me absolutely nothing. I tried to give Stephie an explanation of why something should or should not be done. If she disagreed, she was encouraged to say so in order that we could work it out together.

The most difficult task for me during this time was "keeping my cool," avoiding confrontations when emotions were high as in the past, and not using Stephie as a "scapegoat" for my emotions. Arguments had always left the problem unresolved while each of us remained isolated and angry. Now, patience became the attribute I worked on the most. I consciously tried to stop, listen and communicate.

Stephie had been low on self-esteem and I worked hard at getting her to believe she was "okay." Accentuating the positive became the key to our everyday lives. I reminded Stephie of her good qualities and worked at developing her potential. I praised her when she did well in school, when she showed good play manners, and especially when, on her own initiative, she did nice things for others.

Once in awhile we would spend time together in activities, such as hiking, that did not include her sister. I hoped that these outings would strengthen Stephie's individuality and show her that she was accepted as a person, liked as a friend and loved as a daughter.

Teaching Stephie to dance was another way of encouraging self-expression. She enjoyed dancing, and singing as well. The fact that we had no radio in the car made no difference; we would sing the songs we knew or make up new ones as we went along. It was fun for both of us, and hopefully made Stephanie feel less inhibited in encounters with others. I also tried not to embarrass or tease Stephie by using such statements as "you're too big to behave like that," since these might belittle her and promote withdrawal.

During the months after we began "operation communication," I learned more about myself and shed the old persona to become a better model for Stephie. I learned to "hear" the feeling in Stephanie's words, to know when she wanted "warm fuzzies" even if she was giving "cold pricklies." We became more closely united by the understanding that nourished a struggling relationship into a positive bond of love and acceptance. Time we spent together was measured by quality, not quantity.

"Operation communication" is by no means complete; it is an ongoing transaction and one that will continually be evaluated and improved upon. But we are happy with the results so far and optimistic about the future. Being human we're bound to make mistakes, but as long as we realize them, accept and learn from them and continue to try ... we can't lose.

Sharon Bala is working as a Licensed Practical Nurse at St. Paul's Hospital in Vancouver. She wrote Operation Communication *while attending the nursing program at Niagara College of Applied Arts and Technology; she is four months away from completing her R.N. She has two children, Catherine Shae, 3, and Stephanie, who is now 6 and doing very well. Sharon describes herself as a "kid fanatic" and hopes eventually to take in a couple of foster children. The poem included with her article is one that she reads often to remind herself of the importance of continuing to develop her motherhood potentials.*

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The EMI brain scanner



Euclid Seeram



Figure 1. *The EMI Scanner showing position of patient on the adjustable couch.*

Progress in diagnostic radiology depends partially upon the development of new X ray equipment that offers increased efficiency, enhanced image detail and greater versatility. One of the most significant of recent technological advances in this area was the development in 1969 of a new type of equipment known as the EMI Scanner capable of providing up to 100 percent more information for neuroradiological diagnosis than conventional X ray techniques. The EMI Scanner (see Figure 1), which is now in wide use throughout the United States, and at least six cities in Canada, (including Ottawa, Toronto, Montreal, Calgary, Edmonton and Hamilton) was developed in England by Godfrey N. Hounsfield of EMI Ltd. (Electric and Musical Industries), a British-based group of international companies. It is based on a development of a technique for scanning the brain in successive layers by a very narrow beam of X rays. The technique that is used is referred to as Computerized Axial Tomography (CAT). Other terms synonymous with CAT are: EMI Scan, CT Scan, Computerized Tomography, Computer Assisted Tomography and finally Reconstructed Tomography. Conventional skull X rays and other examinations such as electroencephalography, radioisotope brain scanning, although considered low risk procedures, do not yield as much information when used alone as the EMI Scanner used alone.

Principles of the technique

The main objective of the EMI Scanning System is to produce a series of images using the principle of tomography (in which layers of the anatomy are radiographed) where each one of the images is derived from a specific layer. The basic components of the system include a scanning unit which houses the X ray tube and two scintillation detectors, an X ray control unit, a computer and magnetic disc unit, a viewing unit, a line printer and a teletype.

The patient's head is scanned by a very narrow beam of X rays. The X ray tube and detectors are coupled so that they are arranged diametrically opposite each other on a common frame in order to receive the X rays that have passed through the patient's head. Two detectors are used so that two contiguous slices of the head can be examined at the same time. Another detector is used to measure the intensity of the X ray source. The readings thus obtained are used to calculate absorption values of the material within each slice where,

$$\text{Absorption} = \text{Log}\frac{\text{Intensity of X rays at source}}{\text{Intensity of X rays at detector}}$$

The X ray tube and detectors scan the patient's head in a linear fashion and 240 readings of X ray transmissions through the head are picked up by each detector as can be seen in scan 1 (See Figure 2). At the end of scan 1, the scanning unit is rotated 1° and is continued for 180°. During this process, which lasts for about 4 1/2 minutes, 43,200 readings will have been taken by each detector and two contiguous slices will have been examined. The readings are stored on a disc file to be fed to the computer which calculates the absorption values in each slice. Figure 3 shows the absorption values commonly encountered in clinical radiology. The values are established on an arbitrary scale on the equipment where water is 0, air -500 and dense bone +500. "These absorption values are used to build up a picture of each slice in the form of a matrix (160x160) of 25,600 picture points. Each picture point indicates the absorption value for a volume of tissue 1.5 mm x 1.5 mm x the slice thickness selected at the corresponding points in the section under examination." (EMI Ltd. 1975)

These values can then be displayed on a cathode ray tube and can be recorded by a Polaroid camera (see Figure 4) or they may be printed out as a numerical 'picture' by the line printer.

Radiation dosage

The amount of radiation administered during any diagnostic procedure is of major concern because X irradiation is damaging to human life. One basic objective of all new equipment design in radiology is to reduce the radiation dose to both the patient and personnel.

In conventional radiography of the skull, the maximum exposure dose to the skin is between 1 and 2.5 R(Roentgens) for a single film. In an EMI examination, the maximum dose is in the order of 2 R and is received by the right side of the head. The dose to the male gonads is considerably less than 0.1 mR(milli Roentgens) and the dose is even less to the female gonads. In summary, the X ray exposure is about equal to that received from a

Within the last decade a new kind of technique — computerized axial tomography — has become available for radiological investigation of the brain. Many experts claim that the information provided by the technique is so remarkable that the term 'diagnostic breakthrough' should be applied to its discovery.

Figure 2. *The scanning sequence which is based on the rotate and translate principle.*

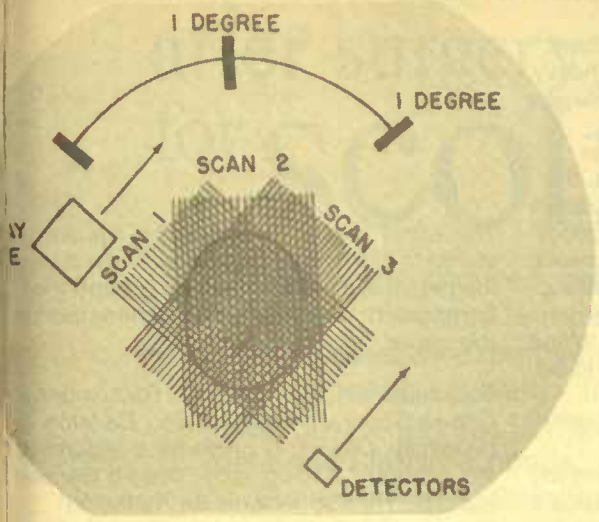


Figure 3. *Absorption of anatomical materials commonly encountered in clinical radiology.*

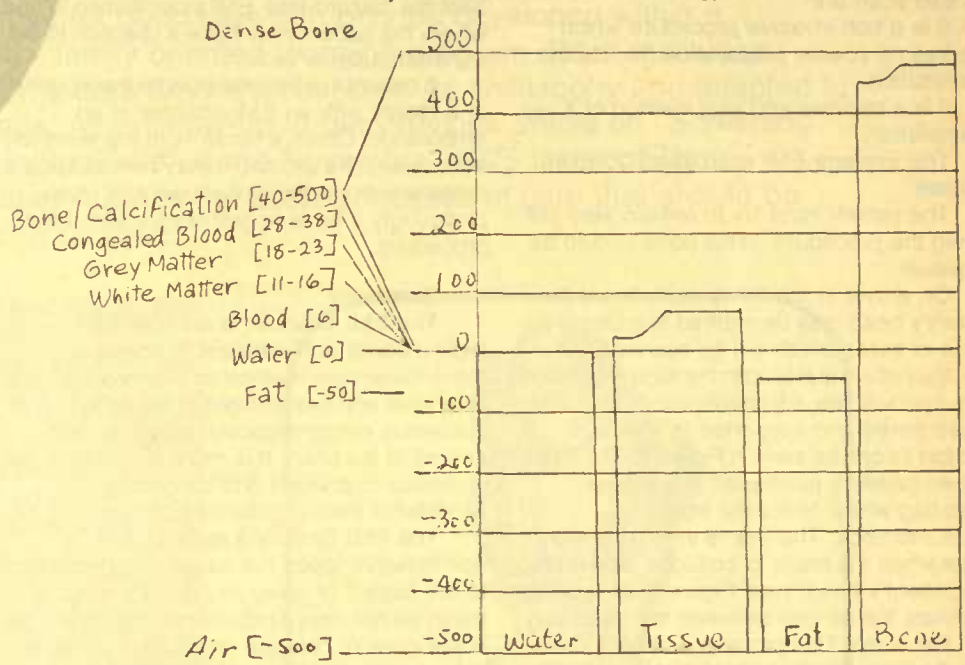




Figure 5. *Patient's head positioned for the examination.*

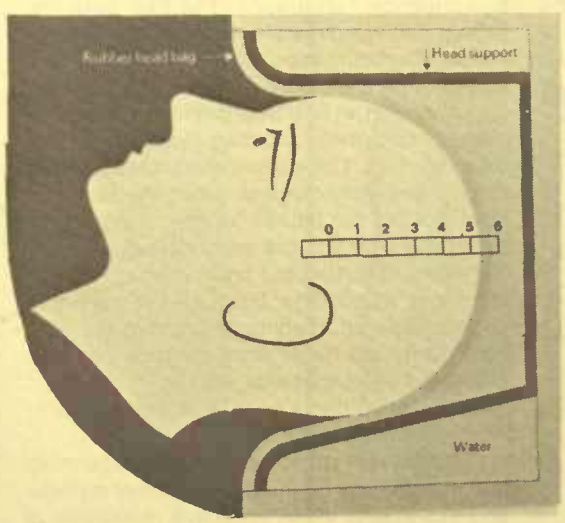




Figure 4. *Polaroid pictures of cathode ray tube screen during the scanning process. (Conray is contrast material or 'dye')*

1835-28 - Infarction.
1757-2A - Hematoma.
2369-28 - Intraventricular meningioma.
1934-58 - Left orbital metastasis from breast carcinoma.
2398. - Right parietal metastasis.
(4A before Conray. 5A after Conray.)

conventional skull examination.

Although the X ray beam is collimated to a very narrow width, there is still a small amount of scattered rays present in the X ray room. Therefore, if anyone is present in the scanning area during the scanning process, then a lead apron should be worn. Usually, X ray personnel and other staff are in a shielded area. Nurses are not usually present during an EMI scan.

What to teach the patient

Patients are anxious to know about their diagnostic examinations especially if they are totally unfamiliar with the test. A clear explanation about what the patient can expect can help in decreasing a patient's anxiety. Some points to emphasize to the patient about the EMI scan are:

- It is a non-invasive procedure which requires no special preparation prior to the examination.
- It is a painless and safe method of X ray examination.
- The average EMI scan takes 30 to 40 minutes.
- The patient *must* try to remain very still during the procedure. (This point should be stressed).

On arrival in the X ray department the patient's head may be marked to indicate the plane of slices which will be scanned. After this, the patient is placed in the supine position on a hydraulically adjustable couch with both knees flexed and supported to maintain comfort as can be seen in Figure 1. The head is then carefully positioned in a rubber head-bag which forms the front of a water-filled box. The box is then filled with water when it is made to 'collapse' slowly onto the patient's head, (see Figure 5) in order to eliminate the air gap between the head-bag and the scalp. This process does not cause any discomfort to the patient. Using water and eliminating the air gap ensure accurate results and help to simplify the calculation.

Patient movement during the scanning will produce blurred images and hence a poor examination. Therefore it is of utmost importance that the patient be immobilized. Although seldom used, in some cases, heavy sedation or even general anesthesia may be given to restless patients.

Sometimes, the patient receives an intravenous injection of contrast media, the purpose of which is to enhance the contrast in the image in situations which are ambiguous. For example, the injection of contrast media can help to differentiate between neoplastic and non-neoplastic lesions. This may then alter the 'hazard-free' EMI examination to one where the patient may have a reaction to the contrast material used.

A patient in a hospital may be transported to a facility with an EMI scanner in an ambulance. Often, a nurse from the ward will accompany the patient. It may help to send a nurse whom the patient knows and trusts, particularly if he is apprehensive about the procedure.

Summary

The EMI Scanner is an important technological achievement. It opens up a remarkable new method of neuroradiological diagnosis and has resulted in the detection of numerous cerebrovascular diseases and tumors of the brain. It is more sensitive to the presence of primary and secondary neoplasms than is radionuclide scanning.

The EMI Scanning technique is non-invasive; does not cause any discomfort to the patient or carry any definite risks of paralysis nor does it require hospitalization, as is the case of cerebral angiography and/or pneumoencephalography. The EMI scan examination also results in a reduction of other problems relating to patient management such as post-operative care etc.

Although an EMI Scanner is an expensive piece of equipment, costing close to half a million dollars, it offers many advantages both clinical and technological. Since the Scanner does not put the patient 'at risk,' it can be extremely useful in the early detection and diagnosis of suspected brain injuries and disorders. In addition, because the patient is not hospitalized, diagnostic costs to the community are lower since patients can be examined as outpatients with no hospitalization costs or 'loss of employment income to the patient.'

All the data collected during EMI scanning are stored either on magnetic discs or on tape and this results in retrospective reanalysis of the information. There is no need to re-examine the patient if the Polaroid pictures are lost or misplaced.

Presently, the principles of the first EMI Scanner have been extended to generate other equipment capable of providing X ray examinations of any part of the body. These are referred to as whole body scanners .

The author wishes to express his sincere thanks to EMITronics Inc., for their help durin the preparation of this manuscript and the permission to reproduce all the figures used this paper.

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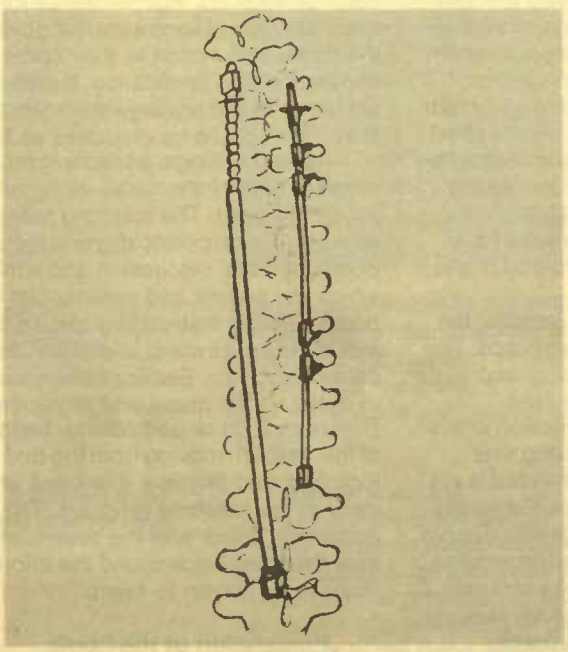
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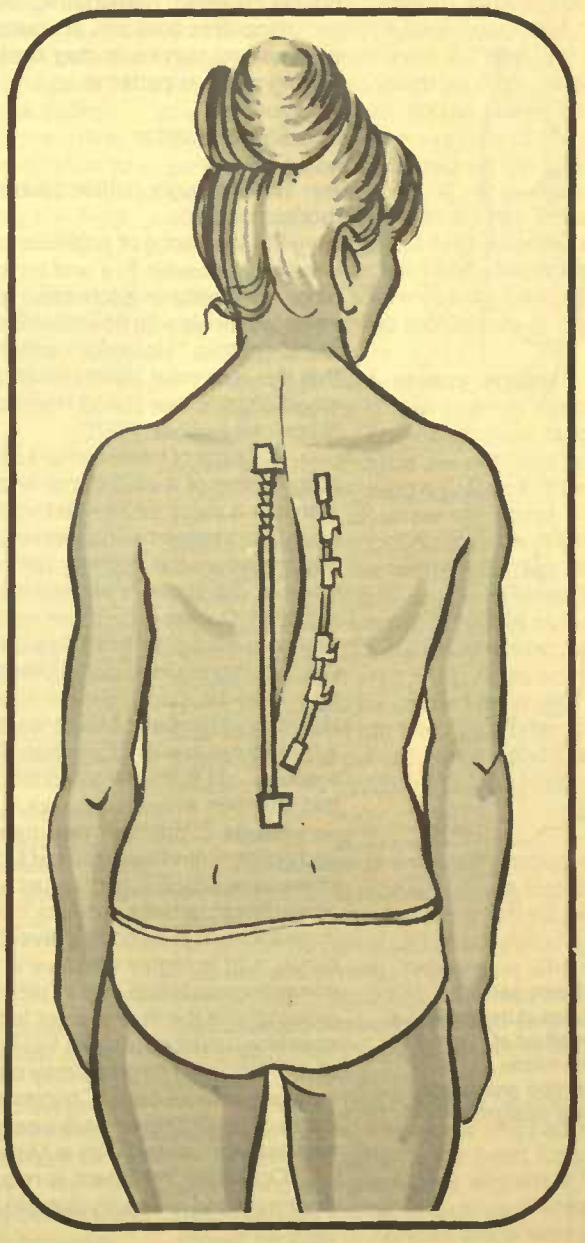
Home care after surgery for scoliosis

Consistent, knowledgeable care given in the home by the parents is a crucial factor in the rapid and healthy recovery of a scoliosis patient after surgery. The necessary expertise for good care can only be developed within a comprehensive patient - family oriented teaching program. Each institution must devise its own home care program based on its philosophy and adapted to meet each family's needs. As a follow-up to her previous article on "Screening for Adolescent Idiopathic Scoliosis" in the November, 1975 issue of The Canadian Nurse, the author outlines the basic principles of care that should be included in such a teaching program.

Ina V. Reid

Parents are normally highly motivated to learn how to give care to their children. Adolescents convalescing after Harrington instrumentation and spinal fusion need to actively participate in decisions concerning their care. As much effort as possible should be made to allow them to follow a normal routine, within the limits of the surgeon's instructions. Both parents and patients need teaching, support and reinforcement from the nurse. They need to know how they are coping. The parents need to be supported and reinforced in their performance of home care and in their acceptance of the patient within the family life-style. Adolescents need to be supported in their independence and adjustment to their new and temporary immobility. Assessment of the home and an informative teaching program on home care needs to be initiated as soon as possible after surgery.





Courtesy of Bruce Stewart and Biomedical Communications Dept. UBC.

Figure 1 Bilateral Harrington rods are attached to the spine in the surgical treatment of scoliosis.

Courtesy of Shirley Mohyudden.

Courtesy of Shirley Mohyudden.







Figure 2
A Milwaukee brace used for flexible curvatures of the spine is a conservative method of treatment. It combines the forces of longitudinal traction and lateral pressure to help straighten the spine.

Scoliosis is a lateral curvature of the spine. Although there are some 31 etiological factors, the most common causes are idiopathic, paralytic and congenital.[1] There are two main classifications of scoliosis:

- Functional or non-structural
- Structural

Functional scoliosis is a *flexible* lateral curvature of the spine without rotation and is totally correctable. Sit or lie down and the curvature will disappear. It can result from one leg being shorter than the other, from poor posture, or from pain and muscle spasms.

Structural scoliosis is a *fixed* lateral curvature of the spine with rotation of the vertebral bodies in the area of the major curve. Rotation is the turning of the vertebral body on the long axis of its body. Because ribs and muscles are attached to this body, rotation pulls them up, resulting in a hump. Structural scoliosis is produced by abnormal changes in the bone, muscle, or soft tissue of the spine and is not correctable by lying or sitting. When a curve fails to straighten out on side bending, it is called a structural curve. There are several types of structural scoliosis eg. neuropathic, osteopathic, myopathic, etc.

Idiopathic scoliosis accounts for 80-90 percent of structural curves. It may occur in any one of the following curve patterns:

- Lumbar
- Thoracolumbar
- Thoracic
- Double major (either double thoracic or double thoracolumbar).

The incidence of scoliosis in a given population is usually between five and ten percent and occurs more frequently in adolescent *girls than boys.* For years, scoliosis with no known cause was referred to as "idiopathic." However, recent evidence suggests that it is a familial condition and that the mode of inheritance is sex linked dominant *(The Canadian Nurse, November, 1975).*

The aims of treatment of scoliosis are to prevent progression of a mild curve and to correct and stabilize a more severe deformity.[2] There are two types of treatment — operative and nonoperative — depending on the severity of the curve, age, and whether the curve is increasing or expected to increase. Curves grow more rapidly during periods of rapid growth eg. 11 to 13 years in girls, and 14 to 16 years in boys. Once bone growth ceases usually at age 16 to 18, minor curves also stop developing. However, a lumbar curve of more than 40 degrees or a thoracic curve of more than 50 degrees in a teenager of 18 years may continue to grow by one to two degrees every two years.[3]

Forms of nonoperative treatment include: the body cast, Cotrel traction and Milwaukee brace. The Milwaukee brace functions as a stabilizer and sometimes partially reduces the curve (see illustration). It is used to prevent progression of the curve, and is highly effective in improving and correcting moderate curves providing the child is still growing and the curve is not too severe. Generally speaking, children under 11 years of age with a curve of more than 40 degrees may be braced depending on the individual case. Children over 14 years with a curve over 40 degrees are treated more agressively and are not treated with a Milwaukee brace.

Operative treatment is required for obvious deformity and is usually done in the early teen years after most spinal growth is completed. More moderate curves may be passively corrected by plaster casts or traction before surgery, followed spinal fusion and immobilization in a body cast. severe curvature, mechanical correction is accomplished by a combination of spinal fusion a application of distraction rods such as those devise by Harrington. The use of Harrington rods (see Figure 1) is a method of instrumentation which consists of distraction and compression rods tha assist in correcting the curves of scoliosis by providing a distracting force on the concave side the curve and a compression force on the conve side. A spinal fusion of the involved segment of spi must be done at the time of application of the rods

Postoperatively, the patient is usually immobilized on a Foster or Stryker frame for approximately 14 days. Nursing responsibilities immediately after surgery include the monitoring neurological signs (level of consciousness, movement and sensation of lower extremities) a monitoring of vital signs to detect cardio-pulmona difficulties. Sutures are removed on the 14th day a a body cast is applied (see Figure 3). Once the cast completely dry, the patient is sent home. There s will be immobilized in bed for about 4 months. At t end of this time, X rays should show complete solidification of the bone. If bone healing is satisfactory, a walking body cast (lighter in weig than the previous cast) is applied. This is worn f about two months and allows the patient to begi mobilization and to return to school.

The care given at home to the patient can mea the success or failure of the treatment started in hospital. Because of the extensive period of immobilization, the patient and her parents need well-structured and practically-oriented program prepare them for home care.

A good teaching program provides the parer with the knowledge to give physical and emotior care to the patient to promote good recovery an prevent complications; allows the patient to participate actively and constructively in her own care; and fosters independence for both. The overriding aim of such a teaching program is to allo the family to function in their home setting with knowledge and confidence, thereby reducing son of the stress and anxiety inherent in such a situatio Home life should be disrupted as little as possib

In most settings, a teaching program will be t responsibility of the nurse along with the physiotherapist. The teaching program should sta about the fourth postop day and include such tools demonstration, discussion and written materials which the patient and parents can refer when at home. Written instructions should be supplied ar include exercise sheet, diet sheet, cast care and sk care instructions. Each of these should be discusse in detail by the nurse and physiotherapists. Demonstration of bedmaking, bedbath, eating, u of the bedpan, moving from the bed to the stretche logrolling and physical exercises should be done early in the teaching program. The nurse must constantly check with the patient and parents to b sure that they understand the information and techniques shown to them.

Preparation of the home

Early in the teaching program, the patient, parents and nurse should discuss the necessary preparation of the home for the care of the patien



Courtesy of Shirley Mohyudden

Figure 3
Some examples of different types of body casts used after scoliosis surgery.

Suggestions are given on how to prepare the patient's room. Because she may spend four months in bed, a cheerful, bright and well-ventilated room can aid the child in maintaining a positive attitude. A system of mirrors may also be erected in the patient's room to give her a view beyond the room.[5] Certain specific equipment may be required. These can be obtained from the local branch of the Red Cross Society or the ambulance service. For example, a light stretcher is required to transport the patient from her room to other areas of the house. Also, a hospital-type bed, if available, is ideal for home care because it provides a firm mattress and greater height. As an alternative, the parents may decide to make adjustments to a single bed at home. A box-like frame sufficiently large to hold a firm single bed mattress can be made from board and decorated with colorful wall paper. Other necessary items include a flat bedpan, a kidney-shaped basin for mouth care, and a wash basin.

Transportation

Transportation to and from hospital can be a problem and a source of anxiety to the parents. If the patient lives in the same city as the hospital, a station wagon or an ambulance will be adequate transportation in most cases. Patients from outlying areas may need to go by air. In this case, the parents need to book three airplane seats for the patient alone because she needs to lie flat on a firm surface. An ambulance will be needed for transportation to the airport. Many ambulance services allow the patient to remain on the stretcher during the flight until final destination. The airline involved then returns the stretcher to the ambulance service. Because the metal detectors at the airport are sensitive to the stainless steel rod(s) inserted during surgery, a card signed by the physician stating that rods are in place will prevent confusion and long explanations.

At the Vancouver General Hospital, 125 surgical procedures for the correction of scoliosis were performed in 1973 and 1974. Approximately 80 percent of these operations were for severe idiopathic scoliosis.

In 1975, 870 children in grades 5, 6, and 7 were screened for scoliosis in the Vancouver area and 30 children (10 boys and 20 girls) were found to have scoliosis. Only 2 children with curves of 20 degrees required active orthopedic treatment. The rest are being followed closely by their family physician.

*The aim of the screening program is to prevent deformity and minimize the need for surgical correction by early detection.**

** B.C. Medical Journal — Vol. 18, No. 4 April, 1976. Pg. 117.*

Care of the cast

Instructions given on cast care include:
—covering the exposed edges of the cast with waterproof tape cut into petal shapes.
— notifying the physician or orthopedic surgeon if the patient is complaining of pain, blueness or numbness in the limbs, breakage of the cast or the digging of the cast into the skin.
— waterproofing of the cast especially before using the bedpan or shampooing the hair is essential. Waterproofing the cast can be done by lining the cast with Saran wrap or plastic bags. If the cast should become wet, some talcum powder may be rubbed in to decrease the odor and may be dried with the nozzle of a vacuum cleaner or hairdryer.
— sharp objects should not be used to poke under the edge of the cast because of possible damage to the skin. Small objects like bobby pins must not get under the cast as they can cause skin irritation and cast breakdown.
— itching under the cast, a frequent complaint, can be relieved by keeping the patient's room cool, and by using the nozzle of the vacuum cleaner or hairdryer to blow cool air under the cast.

Hygiene

Prolonged bedrest emphasizes the need for good personal hygiene for both comfort and cleanliness. It is important that the patient does as much as possible for herself while in bed and not be encouraged to assume the "sick" role. For example, she can do as much of her hygiene as possible by lying on her side with the basin of water on a small table or chair which is in easy reach. She can apply make-up, change positions in bed, and so forth. Some form of signal system, such as a hand bell, is required to communicate the need for assistance. Hair may be shampooed as often as desired. The cast is protected with plastic tucked under it and folded back, with towels on top of the plastic. The patient may be transported on the stretcher to the kitchen sink (see Figure 4), or the alternative is to place a basin of water on a chair at the patient's bedside. The patient needs to be on her side with her head hanging over the basin. Minor disasters eg. spillage of water, will be less of a problem if the chair and floor are covered with towels or plastic as well.

Red open skin means trouble

Maintenance of skin integrity cannot be stressed enough. The parents are taught to reach under the cast and rub the skin and bony prominences with rubbing alcohol. They should be instructed to check under the edges of the cast at least once daily by pulling the skin down and using a flashlight to look for reddened areas. If these are present, the pressure can be relieved by placing a foam pad in stockinette on either side of the reddened area. The pad must not be placed directly on the reddened area. If an open sore occurs, the physician should be notified promptly. Ointments and lotions must not be used under the cast since they are likely to get into the cast and cause chemical reactions, and irritations of the skin.

Positioning

The hazards of immobility including skin breakdown, pneumonia, muscle atrophy and contractures, constipation, anorexia and renal calculi can be prevented or alleviated by correct and frequent positioning. The patient who develops complications becomes even less inclined to help herself thus contributing to a self-perpetuating cycle. It is crucial that the cycle of complications does not start.

Position in bed needs to be changed at least every four hours. The nurse emphasizes to the patient and the parents the need for proper positioning and good body alignment;[6] demonstrates logrolling technique which the patient should be able to perform alone with practice.



Figure 4

Avoid weight gain

Weight gain causes discomfort and may interfere with respirations if the cast becomes too tight. An instruction sheet on diet given to the parents and patient and reviewed by the nurse, lists the types of food to be eaten and the ones to be avoided. A well-balanced diet including generous amounts of fluid, will aid in healing and in the patient's general well-being. Chocolates, cakes, candies, chips etc. cause weight gain and may also produce acne under the cast (not a pleasant situation for the patient). Bulk foods, such as wholewheat breads, unrefined cereals, and fruits should be included in the diet to prevent or relieve constipation. A mild natural laxative such as Metamucil should also be suggested to aid in elimination in case diet alone is not sufficient.

Meal times are family times and a special attempt should be made to make the patient feel a part of the family by having different family members eating with her. In some cases it may be possible for the patient to be close enough to the kitchen or dining room to take a more active role in mealtime (see Figure 5).



Figure 5

The bedpan problem

The use of a bedpan is often uncomfortable. A body cast makes it difficult for the patient to relax sphincter muscles and to increase intra-abdominal pressure to aid elimination.[7] While in hospital, the patient can be taught how to roll on and off the bedpan with assistance. Hopefully, the practice will have been mastered by the time the patient goes home. However, protection of the bedsheets with a homemade incontinence pad (a piece of flannelette with a plastic underside will do) may be a time saver in the long run. Needless to say, the patient should not be left on the bedpan for a prolonged period of time.

Exercise

Regular exercise is essential to the maintenance of good muscle tone and adequate circulation. The exercises started in hospital, taught by the physiotherapist, continue at home. Deep breathing and blowing up balloons are good for lung expansion and active and passive limb and joint exercises should be done frequently. The parents are encouraged to call the ward, the local public health nurse or VON if assistance is required in doing these exercises or in establishing a program of exercise. A letter of referral goes to these health personnel as well as to the family physician once the patient is discharged.

Boredom

It is easy for the patient to become bored while in bed for such an extended period of time. Anger, apathy, aggression and regression are normal patient reactions to prolonged inactivity. The majority of these patients, as adolescents, are at a particularly difficult time in their lives. Even without the additional crises that their surgery and recovery pose, this is usually a time of turmoil and confusion. Therefore, they need strong emotional support and understanding from their family. They also need help in keeping interested in the outside world and in keeping contacts with friends.[8] Group recreation sessions can be organized to give much needed peer support. The patient may be removed from his room on the stretcher to other rooms of the house, or the porch if the weather is suitable. Frequent visits by friends and relatives help the patient feel a part of things.

The nurse can suggest a variety of activities keeping in mind the age and interest of the child. These can include reading, drawing, crafts, watching T.V., listening to the radio, etc. (see Figure 6). The parents should also be cautioned against devoting all the time and attention to the patient to the detriment of the family unit. Emotional crippling can be the result of too much attention.

Usually some arrangement for schooling can be made either with the teacher or the local school board to have a teacher visit or, if convenient, friends may bring home the school work. A chair at the bedside is ideal for storing books, as a work area or for holding a mirror for combing the hair etc. Reading and homework may be made easier with the use of a slanting table which may be rented or possibly may be made at home.

Body image

With the application of a body cast, many adolescent girls have concerns about breast development and the effect of treatment on other body functions. They may be concerned that the cast will prevent growth or change the shape of their breasts. Their concerns are legitimate and the nurse should approach this topic with sensitivity, reassuring the patient that no disfigurement will



Figure 6

occur. The patient may also have some problems in adjusting to the mother taking care of her more personal body needs. The parents should be warned that shyness or defensiveness may appear.

Advice is needed on the choice of clothes. These should be loosely fitted, usually one size larger than normal to fit over the cast. Shorts, shirts, loose dresses, and slacks are easily donned while in bed.

Walking body cast

At the end of approximately 4 months, the patient returns to the hospital for the application of a walking body cast. With the assumption of the upright position, the patient may feel dizzy and lose her balance. She should be assisted with walking during this period. Shoes which have low heels, and good arch support will help make walking easier. They will help the patient to regain her balance and also adjust to the increase in height.

The change in height that follows Harrington instrumentation and spinal fusion may impose perceptual difficulties,[9] and the cast will have a tendency to "drop" when the patient walks downstairs. She may therefore require assistance with walking.

Cast care continues as before. Exercises should be continued until walking has been well established. The patient may also now sit in a chair, on the toilet and on the edge of the bath. To get up from the sitting position the patient should be taught to press down with the palms of both hands on the chair and push herself up. Once ambulation is fully achieved the patient should return to school.

Some adjustment in clothing is necessary in the walking body cast because of the cast's thickness and contour. Heavy, loose clothing makes the cast less conspicuous and is more durable since clothes tend to wear out rapidly when rubbing against the cast. T-shirts are ideal for both boys and girls. Girls may prefer high collars or scarves and straight lines that conceal the cast and do not draw attention to the waistline.

Final removal of the cast

The patient should be warned that when the final cast is removed she may feel weak and dizzy. However, once normal activities are resumed, her strength will be regained. The skin which was under the cast will be tender and scaly and needs gentle care. Wash with mild soap, warm water and pat dry. Do not rub. Baby oil should be gently applied until the scaliness has disappeared, usually in a few days. Clothes will irritate the skin, so they also should be soft and smooth.

Both parents and patient are instructed on the type and frequency of activities the surgeon would like her to resume.[10] For approximately 6 to 12 months, the patient can walk and may swim. From 12 to 18 months, cycling and dancing may be done. No tennis, basketball, horseback riding or twisting sports are allowed. From 18 months on, the patient may gradually resume all activities except trampoline and platform diving.

After removal of the cast, it is important that the patient continue to maintain good body mechanics, flexibility and correct posture. The patient is told that back stiffness over the fused area may persist since the stainless steel rods are permanent correcting devices. If the growth period was not over at the time of the surgery, the growth will continue above and below the fused area. The unfused back and hips can provide most normal flexibility of motion.

To sum up, almost any young girl or boy can adapt to the greater physical problems of recovery from scoliosis surgery, but the greater emphasis on the psychological care in hospital and preparation of the home and family would make home care much simpler and more effective.[11]

This article by Una V. Reid, R.N., B.Sc.N., M.S.N., was written as a follow-up to a previously published article entitled "Screening for Adolescent Idiopathic Scoliosis." The Canadian Nurse, November 1975. She is presently assigned to Trinidad as Nurse Educator for that region by PAHO/WHO.

The author has made a slide tape program on scoliosis for Dr. S.J. Tredwell, M.D., FRCP(C), Dvision of Orthopaedic Surgery, U.B.C. (See Audiovisual page). The project was funded by the Mr. and Mrs. Woodward Foundation. Thanks are acknowledged to the parents and children who took part in the interview that was conducted for the program; Ms. Margaret Nish, Head Nurse, Health Centre for Children, Vancouver, B.C. and Bruce Stewart, Medical Illustrator and the Biomedical Communications Dept., UBC for photographs used in the article.

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50 years ago, on August 24, 1926, the rolling green lawns of the Parliament Buildings in Ottawa were the scene of an important event in the history of the nursing profession in Canada. The occasion was the formal unveiling of a monument honoring the 2,000 Canadian Nursing Sisters who had seen active service overseas during the war that ended eight years earlier. Contemporary newspaper accounts describe the ceremony as "one of the most brilliant functions ever seen in Ottawa."

About 300 invited guests and 700 nurses, many of them in uniform, gathered under a bright summer sky to watch Jean Brown, (later Mrs. W.A. Thompson of Regina) president of the Canadian Nurses Association for that biennium, make the official presentation of the memorial "to the people of Canada from the nurses of Canada."

Other dignitaries in attendance included acting Prime Minister Sir Henry Drayton, who accepted the memorial on behalf of the Canadian people, Dame Maud McCarthy, war-time Matron-in-Chief, British troops in France and Flanders, and Margaret C. Macdonald, Matron-in-Chief, Canadian Army Medical Corps Nursing Service from 1914 to 1923, who read the honor roll.

The memorial itself is an impressive tribute in white Italian marble. It stands in a recessed bay of the corridor connecting the Library of Parliament with the front entrance of the Parliament buildings. The sculptured panel at its center measures eight by nine feet and is surrounded by a carved marble arch that reaches nearly to the ceiling of the Hall of Fame. The artist who carved the panel, sculptor G.W. Hill, RCA of Montreal, described the finished work this way: "The group on the left represents the courage and self-sacrifice of the nurses who offered their services and lives for the great cause of freedom. Two sisters dressed in the service uniform are nursing a wounded soldier. In the background is 'History' holding the book of records. The group on the right represents noble sisters who left their native country, France, to help the sick and needy. A sister within the palisade is nursing a sick Indian child. Beside her are two Iroquois. In the center, dividing the two groups and presiding over them, stands the draped figure of 'Humanity' with outstretched arms."

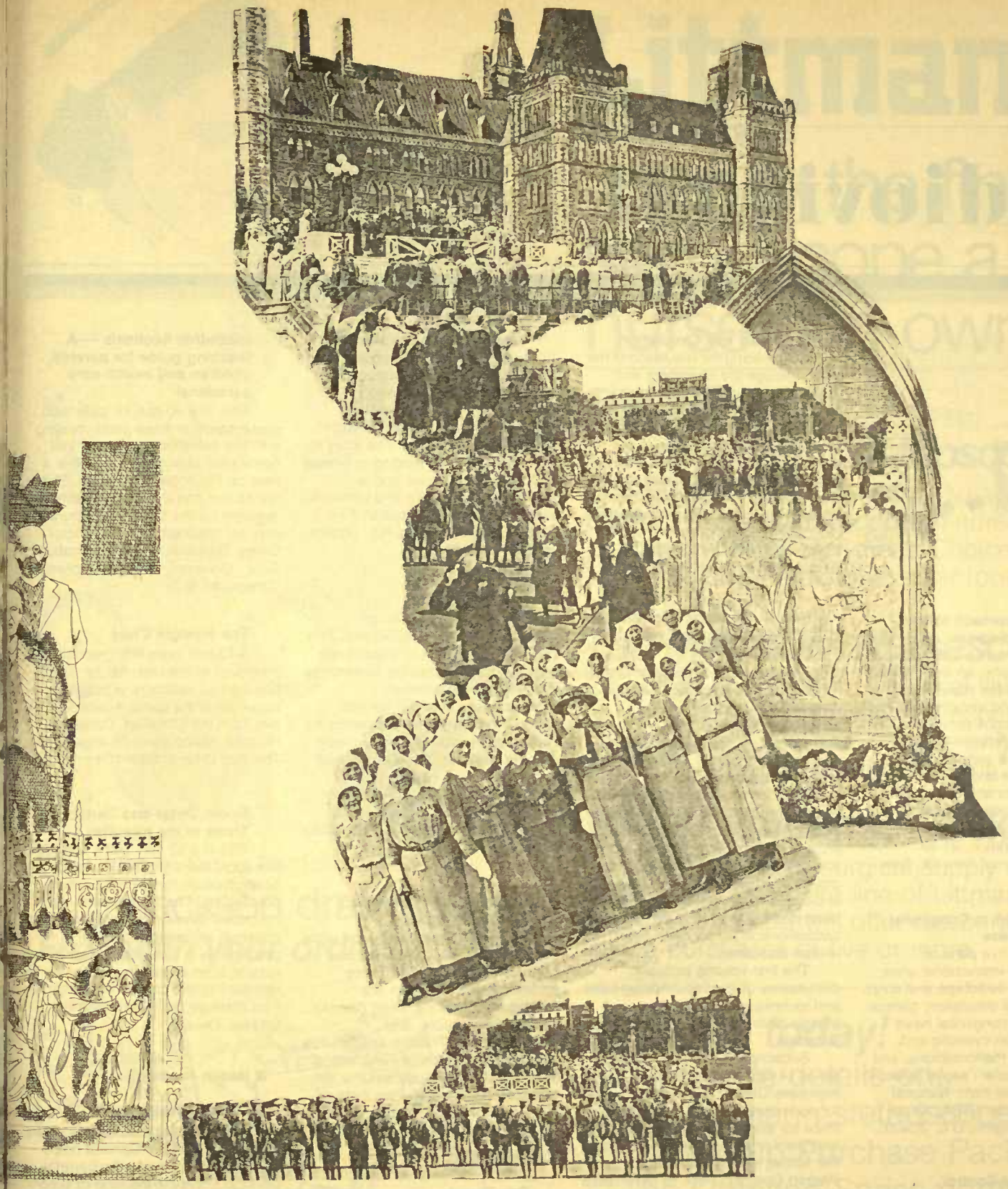
The story of how the nurses of Canada built this memorial is a true-to-life tale of the dedication and perseverance of the organized nursing profession ... In 1921 members of the national association at a meeting in Quebec City agreed to try to erect some form of permanent monument in the nation's capital. During the next five years, CNA members under the direction of the convenor of the memorial committee — Jean Gunn — pursued this goal enthusiastically. They raised close to $40,000,(an amount slightly in excess of costs) from nurses across the country. They sponsored a national design competition that attracted entries from top Canadian sculptors, awarded the contract, supervised construction of the monument and then organized the official unveiling.

The exact site of the Memorial was open to question for some time after CNA members agreed that it should be built and that it should be located in the nation's capital. A representative of the Department of Public Works suggested it should be set in Major's Hill Park, a grassy promontory overlooking the Parliament Buildings and the Ottawa River. In March 1923, Prime Minister Mackenzie King notified CNA that government approval had been obtained for the Memorial to be placed inside the Parliament Buildings, in accordance with the original wishes of the committee. That Fall, a national design competition was announced. The advertisement drew six entries, including that of the winner, G.W. Hill. Original plans had called for Memorial Committees in each province to help decide on the successful artist. When one province relinquished its right in this respect the others followed and a national selection committee was named. Members included: (in addition to the convenor Jean Gunn) CNA President, E. MacPherson Dickson, M.A. MacDonald, Katharine



1914 - 1976



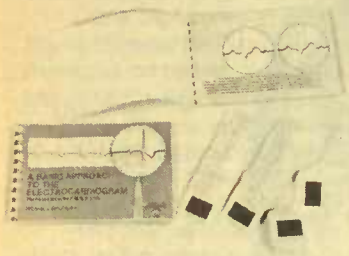


Davidson and Kathleen Russell. Individual provincial nurses' associations were responsible for setting up committees charged with raising the required funds according to the size of their membership and Canadian nurses in all nine provinces responded with overwhelming generosity.

Prime Minister King himself played an active role in some stages of the construction of the memorial. It was, in fact, the Prime Minister, who suggested the wording of the inscription on the memorial, a suggestion which the CNA Executive Committee accepted. This inscription reads:

"Erected by the Nurses of Canada in remembrance of their sisters who gave their lives in the Great War, 1914-18 and to perpetuate a noble tradition in the relations of the old world and the new. Led by the spirit of humanity across the seas, woman by her tender ministrations to those in need has given to the world the example of heroic services embracing three centuries of Canadian history."

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The film may be obtained from Pyramid Films, Box 1048, Santa Monica, California, 90406. Price $300 or Rent $25.

Common Heart Disorders and their Causes

This is a 15 min. black and white film explaining how the heart and circulatory system work. Three common heart disorders are discussed: rheumatic heart disease, high blood pressure, and arteriosclerosis. The film emphasizes the positive aspects of living with a heart condition. To request this film contact the Canadian Film Institute, 303 Richmond Rd., Ottawa, Ontario.

■ Pediatrics

One Tuesday

This 14-min. color film shows a day at the Hospital for Sick Children in Toronto. Available in 16 mm from the Librarian, Canadian Hospital Association, 25 Imperial St., Toronto, Ontario M5P 1C1.

Idiopathic Scoliosis — A teaching guide for parents, children and health care personnel

This is a 90-minute slide tape presentation in three parts, dealing with the definition, treatment and home care of scoliosis. There is a musical break between parts. Slides are 35 mm and a playback machine is required for the tape. The program may be obtained from: Mr. Victor Dorey, Biomedical Communications Dept., University of British Columbia, Vancouver, B.C.

The Straight Child

A 13-min. color film describing the treatment at the Hospital for Sick Children for scoliosis, a progressive curvature of the spine. Available in 16 mm from the Librarian, Canadian Hospital Association, 25 Imperial St., Toronto, Ontario M5P 1C1

Robin, Peter and Darryl: Three to the Hospital

This is a 53 min. black and white film about three children's reactions to hospitalization for minor surgical procedures. The concepts of early childhood development; response to maternal separation; children's perceptions of illness; and methods of nursing intervention are discussed. To request this film contact the Canadian Film Institute, 303 Richmond Rd., Ottawa, Ontario.

■ Health Promotion

Feelin' Great!

A 21-min. color film produced by Health and Welfare Canada helps Canadians to discover the benefits of physical activity in the form of simple calisthenics, walking, jogging, cycling, swimming, skiing, etc. Exercise is the great conditioner, according to this film; it builds a reserve of strength, reduces stress and is nature's great tranquilizer. It takes only a few minutes a day to keep in trim. Available from the Canadian Film Institute, 303 Richmond Rd., Ottawa, Ontario KIZ 6X3.



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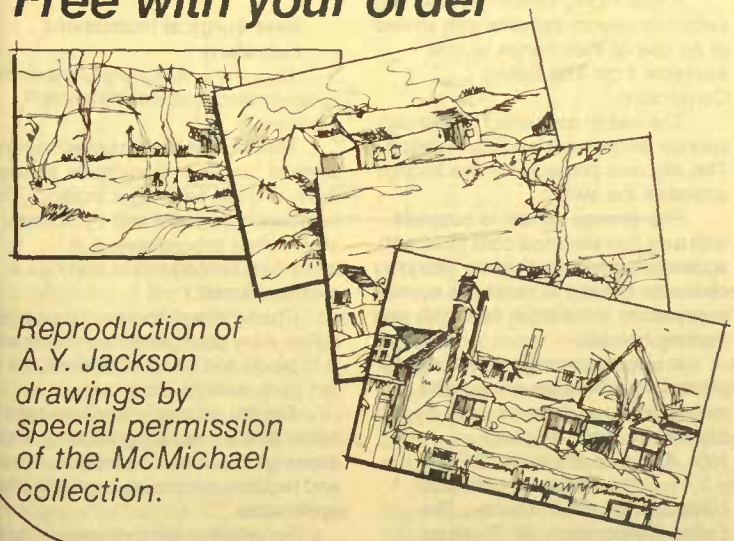
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MEDICAL PRODUCTS

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Information is supplied by the manufacturer; publication of this information does not constitute endorsement.

What's New



Posey Locking Pants

Posey Locking Pants are designed to prevent patients from disrobing or exposing themselves. They are available in plaid prints of washable polyester cotton and may fit over the patient's clothes or be worn as normal clothing. Posey Locking Pants cannot be removed by the patient. They have an inconspicuous keylock on the suspenders to stay in place and may be removed simply and quickly by attendants.

The pants are comfortable, cool, and have a pocket for the patient's convenience. They are available in long or short styles for both men and women, in sizes small, medium, and large. *Approximate price: $24.75 (short), $28.50 (long).*

For further information, contact: Phillip J. White, Marketing Manager, J.T. Posey Company, 39 South Altadena Drive, Pasadena, California, 91107.

Mobile Audio Testing Clinic

The Calumet Coach Company has produced a new self-propelled Mobile Audio Test Clinic. This facility is now being used in Wisconsin to provide hearing examinations and treatments to children.

The 35-foot van is a self-contained unit for independent field operation. The Clinic is equipped with a certified sound room and the test equipment necessary for accurate evaluation of hearing problems. Connection is made to an external outlet for power. Heating, air-conditioning, and water supply systems are installed.

A special treatment room allows the attending physician to make thorough examinations and provide minor treatment. The unit also contains a central reception-waiting area for efficient patient flow.

For information write: Calumet Coach Company, 11575 S. Wabash Avenue, Chicago, Illinois 60628, U.S.A.

Mediset container

A drug container demonstrated to improve compliance with physician's instructions and to eliminate medication errors is now available from Drug Intelligence. MEDISET, a container for all oral drugs, has been used successfully in Europe for several years to help patients with self-administration of medication on a daily and weekly basis.

Recent studies with hypertensive patients by doctors at the University of Cincinnati Medical Center proved that MEDISET has had a positive influence on patients' compliance with their drug therapy schedule.

MEDISET is designed to hold all the oral drugs a patient is taking during one week. Each day of the week is divided into four compartments according to the time at which the medicines are to be taken. The day and hour are clearly marked for each compartment so the patient knows exactly when to take his medication. A window for each pill clearly shows the patient when a dose is due and when a dose has been taken. Braille markings assist the visually handicapped.

MEDISET is made of durable plastic, is easily cleaned and can be used for many years. A profile form located on the bottom of the MEDISET provides a permanent record of all the patient's drugs.

Visiting nurses will find it most helpful for homebound patients taking drugs. MEDISET is also useful in hospitals and nursing homes for drug control and for patient education.

Approximate price: $9.75 each, 10 for $65.00 and 100 for $585.00.

For further information write: Order Department, Drug Intelligence, 1241 Broadway, Hamilton, IL 62341.



Call Switch for Disabled Patients

A new highly sensitive nurse call switch for use by patients with limited or no use of their hands is now available from The Ealing Corporation.

The switch consists of a large soft sponge encasing a sensitive switch. The slightest pressure on the sponge activates the switch.

The sponge switch is supplied with a six foot electrical cord fitted with a standard phone jack plug. The plug connects directly to most call system receptacles installed in hospitals and nursing homes.

In use, the sponge switch can be placed anywhere on or near the patient and can then be used by the chin, head, arm, leg, or foot. *Approximate price: $47.50.*

For additional information contact: Herbert C. Dickey, The Ealing Corporation, 22 Pleasant Street, South Natick, Mass. 01760.

Electrocardiogram after work

Conventional electrocardiograms are made when the patient is at rest. The "Electrocardiogram after work," is recorded in a state of increased physical strain and offers greater diagnostic possibilities. Using this method, it is possible to detect heart damage which would not have been evident in a relaxed state.

Siemens has developed a new medical setup which allows such examinations to be carried out in any physician's consulting rooms. The patient, connected by electrodes to an ECG unit, sits on a bicycle ergometer and pedals at a prescribed speed which can be read on the speedometer. At intervals of a few minutes, the amount of work is carefully increased by means of gradual electromagnetic braking. After the exercise, an ECG is recorded on the multi-channel recorder for about five seconds each time. During the exercise, the physician watches the ECG on an oscilloscope which simultaneously indicates the patient's pulse rate.

For more information contact: D.G. Schandera, Public Relations, Siemens Canada Limited, P.O. Box 7300, Pointe-Claire, P.Q., H9R 4R6.

New Surgical Instrument Lubricant

Depuy Inc. has introduced a new concentrated surgical instrument lubricant.

Stella-Lube lubricates all moving parts of surgical instruments to keep them in good working condition. The lubricant is not affected by normal sterilization procedures. It is attractive, homogenous and has a pleasant smell.

The lubricant comes in a one-half gallon easy pour plastic container and is to be diluted one part Stella-Lube to ten parts water before use.

Continued use of the lubricant helps prevent spotting, rusting, and staining. It leaves no sticky residue and requires no rinsing or wiping after application.

For additional information write to DePuy, Inc., Warsaw, Indiana 46580.

Resumes are based on studies placed by the authors in the CNA Library Repository Collection of Nursing Studies.

Research

- **Standards**

Setting Standards for Patient Care. Nursing Research at Saskatoon, Saskatchewan, 1976. *Marion R. Jackson and Eleanor L. Heieren.*

How many patients can one staff member or group of staff members care for adequately and still retain their job satisfaction?

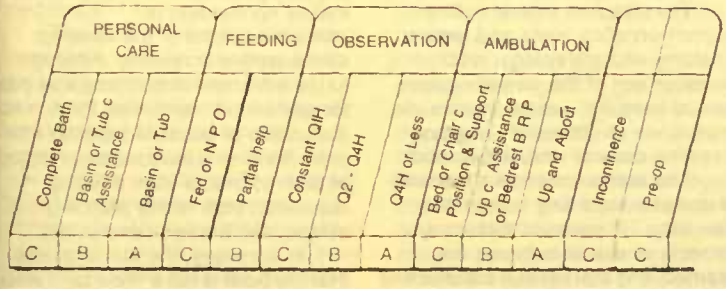
In attempting to effectively meet the needs of patients, various methods of assignment have been utilized in hospitals, e.g. the case, functional and team methods of assignment have been used extensively in hospitals, and more recently, unit assignment has received some attention. No matter which system is used, the problem of identifying the number of patients that each staff member can manage efficiently and effectively, continues to remain with us. As yet, no one has developed criteria which will accurately indicate what a desirable workload would be for an individual staff member.

determiners reflect nursing activities that are performed and repeated at regularly spaced intervals while others are only performed once or twice per 24 hour period. Being subjected to wide swings in workload forces the nurse to contend with the need to set and reset her priorities so many times that she is often forced to omit certain tasks and she recognizes this and begins to lose sight of her earlier high expectations and her morale declines.

The investigator found that nurses were inclined to expect that someone else would improve their working conditions. Nurses were reluctant to identify the care that the patient required because they were weighted down with such a large workload, that they had mixed feelings about stating what the patient's needs were, when they were aware that what care the patient received would actually be less than needed. In coping with this kind of situation daily, one does not need to wonder just why nurses leave the work force.

Setting standards for how much care a patient requires is a must and can only be done with the involvement

PATIENT CLASSIFICATION FORM



The purpose of this study is to test the reliability of the Classification System of patient needs used at the Saskatoon City Hospital.

When examining the major components of the System i.e. Personal Care, Feeding, Observation and Ambulation (Activity) and the two major determiners, i.e. Incontinence and Pre-op., one can readily recognize that all the "C" determiners vary greatly in their implication for nursing care time required in order to meet the patient's needs. To a lesser degree, this is also true of the "A" and "B" determiners. The reason for this variation is *chiefly* because some

of many general staff nurses along with nurses from other sectors of the nursing work force. The general staff nurse is the most closely involved with the patient and she probably has the keenest awareness of how great the gap is between how much care the patient receives and how much care the patient actually needs.

Nurses join the work force full of high expectations and they quickly become disillusioned when they cannot meet their expectations most of the time. The investigator believes that the patient needs to be informed of the type of care he can expect when he enters the hospital. It is also important to alert the patient's relatives to the amount of care that the patient should receive and to involve the relatives in the patient's care.

The study concludes that *the guidelines for the selection of the determiners,* by the nurses classifying patients, should be expanded. This should and did lead to more consistency in classifying patients throughout the hospital, regardless of the clinical service.

- **ICU**

Noise in an intensive care unit, its sources and annoyance to patients. Toronto, Ontario, 1974. Thesis (M.Sc.N.) University of Toronto by *Elizabeth Holder.*



A study of noise, conducted in a 10-bed surgical intensive care unit (SICU) of a university teaching hospital, was centered around the determination of the sources and intensity of sound in the SICU and the patients' perceived annoyance with the sounds. The hypothesis was: those categories of noise perceived by the patient as annoying are those identified by the investigator as the primary sources of sound. The purpose was to provide information on sound sources in an ICU in order that nurses might strive to reduce this stressor in the environment.

Data included information from two sources, sounds in the SICU and interviewing of patients. A sound analysis record of dates, locations of recordings, times, and decibel ranges was devised. Also listed on the record were the sources of sound divided into the categories of Conversation, Other Patients, Equipment and Activities, Life Supporting Devices and Activities, and Other. The interview schedule had the same categories as the sound analysis record. The two stages in the methodology were: 1. measuring sound levels and identifying sources of sound in the SICU, over a period of 12 days during a span of four hours on four days, four evenings, and four nights; 2. interviewing 15 subjects who had been patients in the SICU, but not during sound level recordings, to determine their perceived annoyance with the noise in the unit.

The findings indicated that the average sound level for 48 hours was 56dB(A). The mean sound intensity was higher at night (58dB(A)). Sources of sounds ranked by the investigator according to priority were: Life Supporting Devices and Activities, Conversation, Equipment and Activities, and Other Patients. It was found that for this ICU, sound levels increased as the number of patients increased.

Recordings showed that a high sound level, 90dB(A), was obtained from a confused and vociferous patient. An aneroid sphygmomanometer dropped on a metal shelf, registered 60dB(A); accidental triggering of a respiratory ventilator alarm, 62dB(A). Significant readings of an isolated sound occurred when paper bags were changed in the morning and evening, the decibel measurement being 70dB(A).

The results of the interview showed that sources of noise patients perceived as annoying were, in order of priority: Equipment and Activities, Life Supporting Devices and Activities, Other Patients, and Conversation.

Sources of noise most frequently identified by patients were: lowering or raising bedside rails; humming or clicking of life supporting devices, such as ventilators and wall suctions; other patients moaning or crying out in pain; and the conversation of nurses, especially at report time at the end of the evening tour of duty. Sixty-seven percent of the subjects reported sleep or rest disturbance from the noise during the late evening or night, 13 percent were disturbed during the day, and 20 percent were unable to identify any particular times that the SICU was noisy.

Books

How to Read an E.K.G. Correctly, by Margaret Van Meter and Peter G. Lavine. Jenkintown, Pa., Nursing '76 Books, Intermed Communication, 160 pages. 1975.
Reviewed by Joan A. Royle, Assistant Professor, McMaster University School of Nursing, Hamilton, Ontario.

The electrocardiogram is a valuable assessment tool for nurses only when they are able to use it in conjunction with clinical observations, patient history and laboratory findings. The authors of this nursing skill book emphasize that cardiac arrhythmias must be analyzed and acted upon in the content of their meaning to the patient.

This text provides a brief overview of electrophysiology and the conductive system of the heart. It contains a step-by-step method for analyzing any E.K.G. for rate, rhythm, conduction, configuration and location of waves. Common arrhythmias are discussed according to their area of origin in the S.A. node, atria, A.V. junction and ventricles. The effects of potassium imbalances and myocardial infarctions on the E.K.G. are concisely outlined. The authors provide practical tips on dealing with minor disturbances in the monitoring system.

A variety of tracings are provided for self-testing, and this helps the reader to measure her progress and determine her strengths and weaknesses in interpreting E.K.G.'s.

This short, basic text is clearly and concisely written. It deals solely with the skills required to interpret common cardiac arrhythmias by focusing on several relevant questions: Where did the arrhythmia originate? What effect does it have on cardiac functioning? What treatment is necessary? What are the implications of the treatment or lack of treatment? And what are the implications for nursing? Patient studies presented throughout the book provide examples of application theory and emphasize the importance of interpreting E.K.G.'s according to the total picture presented by the individual.

This book would be valuable to students and to beginning nurses in coronary and intensive care units. Greater depth in electrophysiology and conduction systems is required to enable nurses to analyze and interpret more complex arrhythmias.

Comprehensive Cardiac Care 3ed. by Kathleen G. Andreoli, Virginia Hunn Fowkes, Douglas P. Zipes and Andrew G. Wallace. 342 pages. Saint Louis, The C.V. Mosby Co. 1975.
Reviewed by Myrna Sherrard, Director of Nursing, The Moncton Hospital, Moncton, N.B.

Nurses who are familiar with the first and second editions of "Comprehensive Cardiac Care" will find that the third edition has been significantly revised.

The first chapter provides a brief review of the anatomy and physiology of the heart, basic to an understanding of the material that follows.

The authors present factual information on coronary artery disease, on the physical assessment of patients with the disease and on its complications.

The basic principles of electrocardiography are discussed in detail. There are a large number of illustrations and electrocardiograms related to certain abnormalities seen in patients with cardiac disease. A large section of the book is devoted to cardiac arrhythmias. All electrocardiogram tracings are new and there are two examples of tracings for each arrhythmia discussed. Included in the material presented is a series of rhythm strips. A nurse may use these strips to test her knowledge of arrhythmias by checking her interpretation with that printed beneath the ECG tracings.

The final chapter on the care of the cardiac patient places particular emphasis on prevention of complications and on rehabilitation of the patient. As noted by the authors in the preface to this text, this chapter is presented as the final chapter, not because it is the least important but because it serves as a decision-making process based on the clinical information presented in the preceding chapters.

A section on cardiovascular drugs provides a quick and useful reference on many of the drugs used for cardiac disorders.

The changes made in this third edition have enhanced the value of this book considerably. All nurses involved in the care of patients with cardiac disorders should find this book very valuable, particularly nurses who work in coronary care units and those responsible for the management of patients in cardiac emergencies.

Human Reproduction. by Eric Golanty, New York, Holt, Rinehart and Winston, Inc. 1975. 212 pages.
Reviewed by Mona June Horrocks, Associate Professor, School of Nursing, Dalhousie University, Halifax, N.S.

This book is described in the preface as "a biology book that contains information in journals normally used by students and professionals in the biological and medical sciences," and that is precisely what it is.

The chapters clearly outline human genetics, male and female anatomy and physiology, embryonic development of the sexual organs, sexual behavior, sexual intercourse, maturation of the sperm and ova, venereal disease and birth control.

The author presents a valuable discussion regarding culture and sexuality. He stresses that many aspects of sexual behavior are learned, and that various cultures find different aspects of the human body appealing and erotically exciting. Anyone using this book for a sex education course would find these sections useful in leading a discussion on sex-role stereotyping.

Golanty presents an interesting bias in the use of past and current sexuality studies. He uses current research to validate his statements regarding the myth of the vaginal orgasm, the causes of secondary impotence, and the possible reasons for infertility. However, he uses Kinsey (1948, 1953) in reference to certain other areas. For example, he states that women are not as interested as men in visual erotic material — how do we then explain the booming sales of Playgirl, Viva and Foxylady to women? He also uses Kinsey's statistics regarding heterosexual, homosexual, premarital, extramarital and masturbatory behavior. I would question the value of using such dated statistics in teaching young adults today.

The book seems to be lacking in some areas. For example the author literally describes circumcision, but fails to comment on recent research showing a relationship between circumcision and the low incidence of cancer. The pages on homosexuality are traditional and stereotyped. The section on VD briefly mentions only syphilis and gonorrhea although most books now fully cover all sexually transmitted diseases.

Perhaps the major flaws of the book are contained in the section on birth control. Golanty stresses that both birth control information and prescriptions are to be obtained from the doctor but does not mention family planning clinics, "street nurses," etc. In discussing the "pill," he describes physiological actions in detail, but makes no mention of contraindications or the need for contraceptive screening. Although future advances in contraceptive pills for women are mentioned, there is no discussion of possible treatment for men. Abortion is included as a method of birth control, a view meeting opposition from family planning clinics, well women centers, etc.

In summary, the author states that this book is not a "how to," "when to," or "ought to," book. The book was written because of the author's concern that both students and clients appear to lack all but a rudimentary knowledge of their sexual and reproductive biology. However, biological knowledge alone is not sufficient. I see this book as being useful to the teacher of a sex education course to supply the biological facts. A well-rounded course must deal with other factors including emotional considerations, mutual responsibility, myths and fallacies. There are now a number of good education guides that could be used in conjunction with this book.

Synopsis of Pediatrics, 4ed., by James G. Hughes et al, 1070 pages, C.V. Mosby Company. St. Louis. 1975.
Reviewed by Linda R. Larson, Pediatric Nursing Instructor, Vancouver General Hospital, Vancouver, B.C.

One of the greatest challenges and frustrations of pediatric nursing lies in the development of a working knowledge of a great variety of children's illnesses. This challenge is especially apparent in a pediatric referral or specialty unit. Nurses in such a setting would find *Synopsis of Pediatrics* a useful reference; those involved more generally in the care of children may not.

Synopsis of Pediatrics is written as a physician's handbook and is ambitious in its attempt to cover various aspects of pediatric treatment. Despite the dangers of oversimplification for economy of space, the authors have succeeded well in their task. *Synopsis of Pediatrics* though nearly eleven hundred pages, is light and portable, an advantage not seen in most comprehensive textbooks of pediatrics.

The bulk of the book consists of descriptive data on diseases of the pediatric subspecialties, usually preceded by a brief introduction of embryologic development or epidemiology. Because of topic overlap, it is sometimes necessary to look for information in several chapters to obtain a complete picture of a specific condition. It is unfortunate that the authors have not facilitated this by cross-referencing within each chapter. The initial four chapters bring out some aspects of humanistic studies and philosophy which form the basis of pediatric medicine. The appendices are concise and valuable for quick reference on laboratory values and specific drug dosages.

A word of caution: despite its recent publication, *Synopsis of Pediatrics* should not be used as the sole information source on any topic. Though most of the recorded treatments are similar to those I am familiar with, some do not seem to be completely in tune with current trends. For example, chemotherapy for osteogenic sarcoma is discouraged in spite of its increasing use in contemporary treatment.

In summary, *Synopsis of Pediatrics* has value as a reference for nurses, especially for in-depth explanations of medical rationale or information about less-common childhood illnesses.

Freedom to Die; Moral and Legal Aspects of Euthanasia by O. Ruth Russell, Human Sciences Press, New York, 1975.
Approximate price $14.95
Reviewed by Harriet Hayes, Director, The Miss A.J. McMaster School of Nursing, Moncton, N.B.

This is a well-written book which can be appreciated by anyone. The author discusses active and passive euthanasia, differentiating between the two. She covers both historical viewpoints and contemporary feelings and thoughts on the subject.

The author discusses the court cases of many who were charged with a criminal act after being involved in a "mercy killing." The variety of verdicts arising from similar cases is thought-provoking.

The progress made in the medical field regarding prolongation of life and prevention of disease is also discussed. Presently we have the power to condemn a person to a "living death," but we cannot legally assist them to end this existence we have created for them — even with their consent and at their request. The historical development of the present day controversy on euthanasia is covered in a thorough manner.

The author stresses the importance of the wording of an euthanasia law to provide adequate safeguards. She points out that such a law should be drawn up by appropriate legal authorities. The author leaves any decision for or against euthanasia to the reader. However, she stresses the importance of everyone making a personal decision on the matter; only when individuals let their decisions be heard will any definite or decisive steps be taken to produce a law covering euthanasia.

This book would be excellent for anyone involved in the health field and provides an excellent reference for student nurses.

Nursing Research I edited by Phyllis J. Verhonick. 240 pages, Boston, Little, Brown and Company, 1975.
Reviewed by Dr. Ruth MacKay, Associate Professor, Dalhousie University, School of Nursing, Halifax, N.S.

Ten contributing authors approach research in nursing practice from the points of view of theory building, the research process, and the aspects of investigations relevant to nursing practice problems.

The book is divided into two parts. The first part is addressed to theory building as it contributes to the development of a body of nursing knowledge. Rozella M. Schlotfeldt examines a number of conceptual approaches that are gained through research and used in organizing and structuring knowledge into a nursing science. Imogene M. King comments on a process for developing concepts used in theory building. James Dickoff and Patricia James categorize theories into four types: naming, correlating, predicting and prescribing. They discuss the distinction between a concept and a proposition, and how propositions relate to theories.

Part II discusses the research process in nursing and elaborates on selected aspects of this. Robert C. Leonard, Powhatan J. Wooldridge and James K. Skipper Jr. collaborate to present an overview of the investigative process in nursing practice. To illustrate various points, they describe studies that use theories from the behavioral sciences to suggest hypotheses to explain a particular set of nursing problems, the control of stress by nurses caring for hospitalized patients. The research process is described in some detail. Significant is the use of both subjective and objective means for measuring patient stress as the major outcome variable.

Howard Leventhal and Sherry Israel present a practical discussion of problems of conceptualization, observation, and analysis, pointing out strategies that have been developed in behavioral research, some of the pitfalls, advantages and disadvantages of given courses of action, and ways of obtaining valid and reliable answers to problems of nursing practice. A number of resources are suggested that will permit the reader to examine a particular strategy or discourse in more depth. Throughout, the authors maintain a point of view that research decisions must be made which weigh the gains to be expected in one plan of action against the concessions this may demand, for the greatest additional knowldge to be revealed.

Points discussed in Jeanne Quint Benoliel's chapter are illustrated from experiences in conducting research into the phenomenon of death as it relates to "the lives of three different groups of people: women adjusting to mastectomy and the diagnosis of breast cancer; student nurses encountering death and dying as part of their introduction to becoming nurses; and young diabetics learning the psychosocial meanings of being diabetic." Benoliel also discusses the important aspect of sponsorship in gaining access to the research field.

The book is a welcome addition to the growing collection of resources dealing directly with research in nursing practice. The authors should be commended for making frequent connections of the theoretical issues discussed, to concrete experiences in nursing investigation. The reader is then able to assimilate the ideas discussed into a working knowledge of the application of research methodology to problems of practice.

Although the book is designed to meet the needs of the beginning researcher, it would seem to be more valuable as a reference in the specific areas covered. The book does not give full treatment to all aspects of the research process, and for the beginning student this could be a limitation. It undoubtedly will prove to be a useful resource to the practicing nurse-researcher who faces many of the problems presented here.

Library Update

The following publications, received recently by the Canadian Nurses' Association Library, may be borrowed from the Library by C.N.A. members, schools of nursing, and other institutions. Publications marked **R** however, include reference and archive material and are not available for loan. Theses, also marked **R** are on reserve, and are loaned on an interlibrary basis only.

Loans from the C.N.A. Library may be requested by a letter stating the title of the publication, the author's name, and the item number specified in the following list, or by a standard Interlibrary Loan form. Three publications may be borrowed at one time. Borrowers are requested to cover mailing charges for sending and receiving loaned publications.

If you wish to purchase a book, contact your local bookstore or the publisher.

Books and documents

1. *The Administrative aspects of education for librarianship: a symposium* edited by Mary B. Cassata and Herman L. Totten. Metuchen, N.J., Scarecrow Press, 1975. 407p.
2. *Agence canadienne de développement international.* Rapport annuel, 1974-1975. Ottawa, 1976. 108p.
3. Association des Hôpitaux du Canada. *Annuaire des hôpitaux du Canada,* vol. 24. Toronto, 1976, 360p. **R**
4. Bernard, Jessie. *Women, wives, mothers: values and options.* Chicago, Aldine, c1975. 286p.
5. Burton, John Lloyd. *Aids to medicine for nurses.* Edinburgh, Churchill, Livingstone, 1976. 136p.
6. Canadian Association for Adult Education. *Manpower training at the crossroads.* Toronto, 1976. 64p.
7. Canadian Hospital Association. *Canadian hospital directory,* vol. 24. Toronto, 1976. 360p. **R**
8. Canadian International Development Agency. *Annual Review 1974-1975.* Ottawa, 1976. 108p.
9. Canadian NGO Conference on Human Settlements, Ottawa, Dec. 11-13, 1975. *Report.* Ottawa, The Canadian National Committee; The Canadian NGO Participation Group, 1975, 106p.
10. Carter, Frances Monet. *Psychosocial nursing: theory and practice in hospital and community mental health.* 2ed. New York, Macmillan, c1976. 538p.
11. Cave, Roderick. *Rare book librarianship.* London, Clive Bingley, c1976. 168p.
12. Étude Sommaire de la "Méthode d'Ovulation" de Billings (ESMOB). *Rapport final.* Ottawa, SERENA, 1976. 51p.
13. Flanders, James P. *Practical psychology.* New York, Harper & Row, c1976. 310p.
14. Foundation Center. *The foundation directory, Edition 5, Supplement no. 1.* New York, Columbia University Press, 1975. 79p. **R**
15. French, Derek. *Dictionary of management,* by . . . and Heather Saward. New York, International Publications, c1975. 447p. **R**
16. *Handy metric conversion tables.* Toronto, Coles, 1975. 57p.
17. Institut canadien d'éducation des adultes. *La formation professionnelle en question.* Montréal, 1976. 70p.
18. Institut Marguerite d'Youville, Montréal. *Le soin des malades; principes et techniques.* 2ed. Montréal, 1955. 893p.
19. Institute of Health Services Administrators. *The hospitals year book, 1976.* London, 1976. 1156p. **R**
20. *Maternity nursing case studies: 53 case studies related to maternal and infant care in 13 families,* by Mildred A. Disbrow . . . et al. Flushing, N.Y., Medical Examination Pub. Co., c1976. 215p.
21. Mayes, Mary E. *Nurse's aide study manual.* 3ed. Philadelphia, Saunders, 1976. 283p.
22. National League for Nursing. *Accountability: accepting the challenge.* New York, c1976. 90p. (NLN Pub. no. 16-1621)
23. *Nursing and the aged,* edited by Irene Mortenson Burnside. New York, McGraw-Hill, c1976. 654p.
24. The Nursing Clinics of North America, v. 11, no. 2, June 1976. *Teaching and rehabilitating the cardiac patient.* Toronto, Saunders, 1976. p. 211-387.
25. Organisation mondiale de la Santé. *Activité de l'OMS en 1975 Rapport annuel du Directeur général à l'Assemblée mondiale de la Santé et aux Nations Unies.* Genève, 1976. 362p.
26. Pillitteri, Adele. *Nursing care of the growing family; a maternal-newborn text.* Boston, Little, Brown & Co., c1976. 445p.
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12 76 The Canadian Nurse

The official journal of the Canadian Nurses Association published monthly in French and English editions.

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Christmas is for children... and holidays in the sunny south or on the ski slopes, for getting together with families and friends — old and new. We join the little girl on this month's cover in wishing all of our readers a happy holiday season wherever they may be. (Cover photo courtesy CNA Library Archives)

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

ISSN 0008-4581

Indexed in International Nursing Index, Cumulative Index to Nursing Literature, Abstracts of Hospital Management Studies, Hospital Literature Index, Hospital Abstracts, Index Medicus. *The Canadian Nurse* is available in microform from Xerox University Microfilms, Ann Arbor, Michigan, 48106.

The Canadian Nurse welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-space. Send original and carbon. All articles must be submitted for the exclusive use of *The Canadian Nurse*. A biographical statement and return address should accompany all manuscripts.

Subscription Rates: Canada: one year, $8.00; two years, $15.00. Foreign: one year, $9.00; two years, $17.00. Single copies: $1.00 each. Make cheques or money orders payable to the Canadian Nurses Association.

Change of Address: Notice should be given in advance. Include previous address as well as new, along with registration number, in a provincial/territorial nurses' association where applicable. Not responsible for journals lost in mail due to errors in address.

Postage paid in cash at third class rate Montreal, P.Q. Permit No. 10,001.
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Perspective

As I write this, the crisp, colorful days of October have turned into the shorter, darker, ones of November. Here in Ottawa, the first few traces of snow have already touched the fallen leaves, making it clear that winter is just around the corner. I realize that, by the time that most of you read this, the Christmas holiday season will be in full swing. Christmas is a time for thinking of others so it seems appropriate that in this month's column I should convey some of the messages of appreciation that have been left unsaid all year.

All of us associated with *The Canadian Nurse*, would like to say to all of you: "Season's Greetings," "Merry Christmas" and "All the best in 1977." This expression of goodwill comes, not just from the editorial staff, but from all of those involved in producing this journal — the people who design the book, take the photos, sell the ads and keep track of subscribers. It goes out, first of all, to all our readers — whether they are in Newfoundland, Saskatchewan, Australia, Africa or wherever. We have reason to think that you are coming to identify yourselves more closely with your professional journal. We trust that next year you will not hesitate to make your needs and concerns known to us so that we can share these thoughts, experiences and observations with your fellow-nurses.

Above all, this greeting goes out to everyone who contributed in any way at all to the content of the last twelve issues of this journal. At the top of this lengthy list are all the people who submitted articles during the year — published and unpublished authors alike. The selection process eliminated many contributors from the file of accepted authors. This does not mean, however, that their efforts went unnoticed. We hope that they will be encouraged to try again.

To the authors, illustrators and photographers whose works *were* published — thank you more than we can ever say for sharing your time and your talents.

To all the contributors whose names did not appear in print, to our book reviewers, people who sent in information on news events, calendar items and people in the news — another sincere note of appreciation. We need you!

To all the nurses in the various provincial associations that I visited during the year — thank you for making me feel at home wherever I went and for sharing your ideas with me. It was great meeting you and I look forward to seeing you all again in 1977.

— M.A.H

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Herein

This month we're reviving a feature that many readers will remember from years gone by. **"Idea Exchange"** is your chance to share your unique brand of expertise or original thinking with your colleagues. This month on page 17 four students describe their foray into the world of the very young school child. If you have a procedure or experience that's a little different or better than most, let us know about it and we'll spread the word.



Psychologist John Allan believes that the signs of behavior problems to follow are apparent at a very early stage to the sharp eyes of a knowledgeable observer. Public health nurses, according to Dr. Allan, are in an ideal position to warn parents of the danger signals exhibited by the "difficult baby" and to help them modify this behavior by means of some very simple and practical suggestions. "Difficult babies" is an article that any nurse or mother who is concerned about child development will want to read. It begins on page 11.

Conventional wisdom indicates that, in this life, only two events are inevitable: death and taxes. **Next month,** financial columnist, Mike Grenby takes a look at how nurses can save themselves some money when they find they can no longer put off settling their account with Revenue Canada.

Saunders' 1976 Nursing Titles:

Here are 20 ways— that Saunders helped nurses this year.



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The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

Input

Nursing research papers

Due to popular demand, there has been a second printing of *Development and Use of Indicators in Nursing Research,* the Proceedings of the 1975 National Conference on Nursing Research. Contents include (1) major papers by: Professor Lisbeth Hockey (University of Edinburgh), on Social Indicators, Dr. June Abbey (University of California at San Francisco), on Physical Indicators, and Dr. Jack Hayward (Department of Health and Social Security, London), on Psychological Indicators; (2) major papers and critiques regarding fourteen Canadian nursing research projects; and (3) a paper on issues and alternatives regarding organization for nursing research in Canada. Copies are available at $2.00 (prepaid) through: University of Alberta Bookstore, Edmonton, Alberta, T6G 2J7.

Would you please let your readers know about this?
— Shirley Stinson, R.N., Ed.D., Faculty of Nursing, University of Alberta, Edmonton.

Canadian nurses at the Olympics

Montreal still appears to be riding out the glory of the summer Olympics. For two weeks, the city was a sea of enthusiastic, happy citizens, athletes and visitors, all experiencing the birth of Mayor Drapeau's billion dollar baby. From July 17th onward, little was heard of the exorbitant costs from those who will bear the brunt of such costs .... the citizens of Quebec.

News media most critical of the whole Olympic scene since the idea of Montreal's hosting the games was first conceived, came out in favor of the movement the day of opening ceremonies. Hopefully their critical enthusiasm before the games will not be lost in sentimental euphoria in the post Olympic search into exorbitant costs.

The aftermath of the games offers a time for reflection and placing priorities in their proper perspectives.

We would like to raise the subject of members of the medical team (nurses, doctors, physiotherapists) who volunteered their services in exchange for seeing the games.

According to Dr. Georges Létourneau, in charge of COJO health services, the original games health program, estimated at $720,000 for six hundred (600) nurses, was considered "too expensive." COJO's recruitment committee cut down its allotment and decided to ask for volunteers. It is ironic that health service budgets were cut while costs in other areas which soared beyond all belief were simply ignored.

Forty-four Canadian nurses were chosen out of the 150 who offered their services in exchange for travel and lodging (for those outside of Quebec), and a $25. per day stipend to cover meals and small expenses. Twenty-five physiotherapists were recruited under the same stipulations, while 220 doctors (half from outside Montreal), were recruited for $40. per day plus travelling expenses. Since they were all volunteers, one wonders whether the meals cost more for doctors than for nurses, hence the $15. difference .... or was it not the old double standard at work again?

COJO claims it cost as much to lodge the nurses who came from outside Montreal at a $25. per day stipend as it would would have cost to hire nurses at the going rate. At the same time it stated that all the nurses had eight or nine years' experience in speciality areas such as ICU and Emergency.

The daily basic rate for a nurse with this experience is just about $56. excluding shift, responsibility or speciality differentials, fringe benefits and vacation pay (which must be paid to salaried employees according to minimum wage requirements).

Nursing services cost COJO about $23,100 apart from lodging, (2 weeks of games plus 1 week training). Under Quebec's negotiated rates, which are still lower than some Canadian provinces, this would have cost approximately $51,744 if each nurse worked one shift per day, which we are told they did not, as they were given days off. We doubt that it cost COJO $28,644 to lodge the nurses who came from outside Montreal.

As to whether or not the nurses actually saw many of the events (presumably one of the most enticing reasons for offering their services) — Dr. Létourneau explained that "most worked at the Olympic Village Clinic and did not see the games." He said that they did see parts of the opening and closing ceremonies and those who worked at the Velodrome saw some events.

An estimated 15,862 spectators and athletes in all were given medical treatment. With only 44 nurses working shifts, we assume they had to be busy most of the time.

One can argue in favor of the volunteer aspect of the Olympic Games. It is not every day your country or city hosts an Olympics, so why not take advantage of being at the heart of where it was all happening? It was an exciting time to be in Montreal. After all, it is a free country, so why should people not volunteer services if they please?

All true ...*but* the fact is that nurses as a group have been volunteers for so long, they're still *expected* to be volunteers.

COJO knew it could save money by getting nurses to work for next to nothing. Everyone would have been surprised if nurses had not volunteered .... they would not have been handmaidens to COJO had they not done so. Nurses never turn away from the needs of mankind whatever the price — or lack thereof. Where else, outside of health services would the Olympic program dare recruit volunteer workers?

Last year while the Olympic installations were being built, newspapers carried reports of construction workers and foremen on the site earning in some cases $1,000 and more per week. At the same time, a first echelon nurse working in a life-saving situation in a Quebec hospital earned a basic salary of $136. per week.

Was the life-saving intensive care situation not worth as much in terms of value as the construction of the Olympic installations?

Professional and union organizations repeatedly find their efforts hampered by such situations as they work strenuously to uncover and rectify existing inequalities between different categories of workers, upgrade salaries, social benefits and working conditions.
— Marie Mullally, Syndical Consultant, The United Nurses Inc., Montreal, Quebec.

Ontario Orthopedic Nurses

As a result of tremendous enthusiasm from Ontario members for the Orthopedic Nurses' Association, Inc., Atlanta, Georgia, two Canadian interest groups have been formed in association with the national organization. The original interest group from Toronto assisted with the initial phase, of starting the Hamilton Interest Group and has maintained close co-operation with us. Today, both are thriving.

The purpose of these interest groups is to assist R.N.'s and R.N.A.'s involved in the care of the orthopedic patient with maintaining current knowledge through a variety of continuing education activities. Our programs are open to other members of the Health Team who share similar interests on behalf of the orthopedic patient. Basic to the programs is the theme of physician management and nursing care, planned co-operatively.

As the yearly congress of the Orthopedic Nurses' Association has been attracting nurses from several other provinces, we are interested in learning of other Orthopedic Interest Groups. We would like to hear from nurses who are now involved in or anticipate forming local chapters.

Please contact: *Mrs. N. Campbell, 1244 Richmond Rd., Burlington, Ontario, L7S 1K6.*

Bare surnames

Since I have received *The Canadian Nurse* for over 25 years, am sure I would be described as an "old-timer," and as such I am taking exception in your literature to the use of last names throughout all articles.

I find myself cringing while reading articles in case I will come upon the "bare surname."

I appreciate that this is no doubt the modern trend in literature, but find it very abrasive in "our" professional magazine.
— M.A. Wickham, R.N., Director of Nursing Services, Ontario Crippled Children's Centre, Toronto, Ontario.

Editor's note: *Titles such as Miss or Mrs. are omitted to comply with a resolution from CNA membership (June, 1974) that applies to all CNA communications. We would, however, welcome comments on this topic from other readers.*

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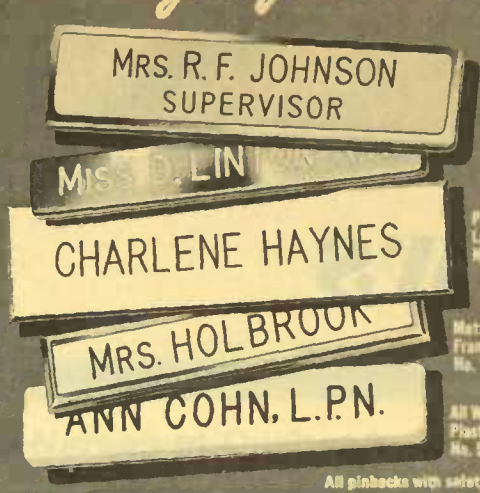
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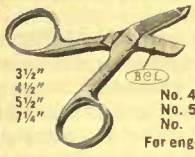
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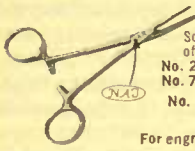


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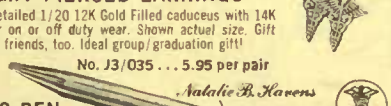
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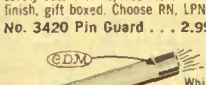
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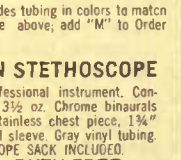
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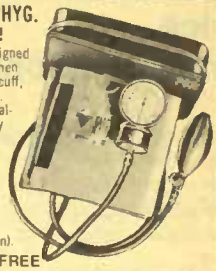
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News

CNA to provide consultation service in labor relations

Effective January 1, 1977, the Canadian Nurses Association will establish a Consultation Service in Labor Relations to provide information and relevant education to its members.

According to the Board of Directors of CNA who met in Ottawa October 21 and 22, the prevailing social and economic climate has precipitated the need for such a service in the nursing field. It will be available to all CNA members.

The structure of the organization will be developed in conjunction with the national Collective Bargaining Conference, which is composed of representatives from CNA member associations, the nursing group of the Professional Institute of the Public Service of Canada and collective bargaining groups for nurses at the provincial level.

President Joan Gilchrist, commenting on the decision, said: "CNA supported the initiation of collective bargaining for nurses in Canada and has always approved the principle of optimum working conditions in order to provide high standards of patient care."

Special meeting planned

Concern over the need to provide direction and guidance to the nursing profession at the national level, prompted CNA Directors to call a special "work session" of Board members to take place in Ottawa January 10 and 11, 1977. The meeting will explore "Regulation of the Profession" as it relates to nursing directions: the power and purpose of the nursing profession in Canada today.

Participants will discuss current issues and trends and attempt to assess the current power existing in nursing, establish directions for the future and to identify external forces influencing the profession. Careful study will therefore be made of nursing education, practice, administration, research, legislation and social and economic welfare.

Priorities for the 1976-78 Biennium

CNA Directors have a clear mandate for the 1976-78 Biennium, to continue work on the development of standards for nursing education and practice, the preparation of the comprehensive exam , the establishment of the Consultation Service in Labour Relations and Workshop on Research Methodology in Nursing Care. Other priorities may be identified following the next meeting of the Board of Directors, March 30 and April 1, 1977.

Health happenings in the news

Grant MacEwan Community College in Edmonton, Alta., has been given approval by the Department of Advanced Education and Manpower to implement an **Extended Care Nursing Certificate Program,** the first of its kind in Canada. Areas of care to be covered, will include geriatrics and rehabilitation, convalescence and care of persons with long-term or chronic illness.

The two-trimester Extended Care Nursing Program is designed to provide opportunity for registered nurses to gain and/or upgrade the knowledge and skills required in a variety of extended care settings. On completion of the program, candidates will obtain a certificate in Extended Care Nursing.

Nurses are being asked by the Registered Nurses' Association of B.C. to document situations which indicate that **provincial government fiscal restraints** may be affecting patient care in hospitals.

President Thurley Duck notes "there is continuing talk about poorer patient care because of funding problems. This is an appeal for more than talk. If there are things wrong, we need facts. Without these facts, it must seem that cost containment is not threatening the quality of patient care. Hopefully, that is true. But we need your help to be certain."

She reminds nurses that Health Minister Robert McClelland earlier this year restored some public health cutbacks, following his receipt of nurses' and other documentation on the adverse effects on patient care. "As things stand now, however, no such documentation has been received about conditions in public hospitals."

Donna Lynn Smith, director of nursing at Lethbridge Rehabilitation Hospital, received a $5,000. grant from the Alberta Mental Health Advisory Council this past summer to conduct research into mental health.

Dr. C.P. Hellon, director of mental health services for the province said that approximately 60 applications were received this year. The grants program is the result of recommendations contained in the 1969 Blair report which urged more research for mental health topics in Alberta.

Smith intends to develop a program whereby social service or health workers are trained to recognize "health potentials" in clients and to reinforce them, rather than the symptoms of ill health taught in the medical model of treatment. An important part of the research, conducted at The University of Alberta, will involve devising methods of teaching the health workers to 'value aspects of mental health' and to recognize what constitutes mental health.



Photo courtesy Bell Northern Research

Medical staff at Moose Factory General Hospital near James Bay are taking part in an experimental study using a highly advanced communication system that may foreshadow future modes of health service. **Nabila Lowe,** *B.N., B.Sc.N., (left) and* **Debbie Gooding** *R.N., B.Sc.N., both Public Health Nurses, were among the first to take advantage of the space age communications technology while installation work went on around them. They are seen here conversing by satellite with colleagues at University Hospital, London, Ontario about methods of patient education in the management of diabetes. The system was specially engineered in Ottawa for the federal Department of Communications. It is designed to give medical personnel an unparalleled degree of contact regardless of distance. In addition to the link to London, Ontario, there is access to the remote nursing station at Kashechewan on the Albany River. The experiment is one of a series using Canada's Hermes satellite to probe the social impact of satellite communications.*

Don't hold your breath

A one-day seminar sponsored by the Toronto Nurses' Section of the Ontario Lung Association focused sharply on meeting the needs of the patient with chronic obstructive pulmonary disease— in the hospital, in the intensive care unit, and in the community.

The October seminar directed attention to the assessment, nursing management, and meaningful teaching of patients with the disease, and was emphatically practical in nature.

Dr. Reuben Cherniack, M.D., of the University of Manitoba and Health Sciences Centre in Winnipeg, began the program by reviewing the physiology of the lung and aspects of functional assessment of the patient with chronic obstructive pulmonary disease. In his introduction, he differentiated the disease processes and manifestations of chronic bronchitis, emphysema and asthma. His discussion provided a baseline from which the needs of the C.O.P.D. patient could be discussed.

Using a detailed patient care plan, Sandra Truesdell, Critical Care Supervisor at St. Joseph's Hospital in London, discussed the needs of the C.O.P.D. patient in the hospital setting. She reviewed these needs as the patient perceives them, as the nurse observes them, and as the nurse assesses them and evolves a plan for care and teaching.

Truesdell's plan emphasized the importance of the teaching role of the nurse regarding medications, complications (infection and congestive heart failure), and activity of the patient. She said that in order to teach breath control measures effectively, both the nurse and patient must know "what the patient does to aggravate his shortness of breath."

The way to modification of behavioral patterns begins with the patient's examination of his activities of daily living. Knowledge of what makes him short of breath will determine his specific activity limitations and help him to control his anxiety. "In hospital," Truesdell said, "the nurse is just scratching the surface," adding that home care referral is a necessity in helping the patient to pace his activities on a daily basis.

A panel discussion dealt with the needs of the patient in ICU. Ruth Kitson, Head Nurse, Maureen Morrison, Physiotherapist and Natwarlal Naik, Respiratory Technologist, talked about the team approach to the care of a long-term intensive care patient—from acute care, through weaning from the ventilator, rehabilitation and transfer to a medical ward. Their presentation was illustrated by slides showing the progress of one of their long-term patients at the Toronto Western Hospital.

Lee Robinson, Clinical Specialist at St. Joseph's Hospital in Hamilton follows respiratory patients on an on-going basis in their homes, at the out-patient clinic, and in the hospital, through the McMaster Regional Respiratory Program. Her contribution to the seminar involved showing how effective teaching can help patients to attain behavioral change and an acceptable level of health, in spite of permanent changes inherent in chronic lung disease. She discussed practical measures to help the patient learn how to control his breathing and to increase his activity gradually through teaching him specifically "what to do and how to do it."

A responsive audience of close to 200, including nurses, physiotherapists, respiratory technologists, medical students and social workers attended the seminar in Toronto. It was the second seminar on chronic obstructive pulmonary disease to be sponsored by the Toronto Nurses' Section of the Ontario Lung Association.

Did you know ...

French investigators say they have developed a vaccine against hepatitis B, tested it clinically and first results indicate it is protective. *(The Lancet, June 26).*

Its only use so far is in one hemodialysis unit to protect patients and staff but the investigators say that it could be given to others at high risk.

Order of Nurses of Quebec holds annual meeting in Montreal

The Order of Nurses of Quebec has joined most of the other provincial nursing associations across Canada in raising its annual membership fee. The decision by the ONQ Bureau to increase the yearly fee for active members from $55 to $80, effective 1977, was announced at the annual meeting of the Order in Montreal in late October.

The 48,000-member ONQ, in budgetary provisions for the fiscal period of April, 1977 to March 31, 1978, anticipates expenditures of more than $2.75 million for the next fiscal year.

According to ONQ officials, the increase is needed to cover additional expenses incurred by application of the new Professional Code and nursing legislation. In answer to a question from delegates, an ONQ spokesman cited figures to show that, even with the increase, nurses will pay less for membership in their association than almost any other professional group in Quebec.

As a result of legislative changes, there has been an increase in the decision-making power at the level of the Bureau (which consists of an administrative committee, one representative from each district, and three directors appointed by the Office des professions du Québec) and a corresponding loss of power at the level of the General Assembly. Delegates asked that officials of the Order endeavor to obtain government approval for changes in the Professional Code that would promote increased membership participation in the decision-making process.

Delegates also discussed a wide range of resolutions, including one previously adopted by the Bureau that the Order's newsletter, "Nursing Quebec," become a unilingual French publication. Opposition to this move resulted in a recommendation that the Order continue to publish in two languages to meet the needs of both French and English members.

Other resolutions included recommendations that:

- the ONQ request the *Régie de la langue française* to define "working-knowledge of the French language" and establish the criteria pertaining thereto, as these relate to implementation of the Official Language Act;
- the ONQ require that all candidates to the practice of the profession be tested to detect any anomalies in their color perception, (color-blindness) to be followed by a qualitative and quantitative diagnosis, if necessary;
- pressure be brought to bear on the Department of Social Affairs by the ONQ so that an appropriate test to detect anomalies in color perception may be given to all kindergarten children by the school nurse.

IDRC awards

Ten awards for **"mid-career professionals"** are being offered again this year by the International Development and Research Centre. These awards are designed for professionals or practitioners with no specific experience in international development as well as for those who are already working in this field. They offer a "sabbatical year" for research, specialized training, personal study or updating of skills. Candidates may present projects in any of the numerous areas dealing with international development, such as agriculture, nutrition sciences, health sciences, engineering, social sciences, communications, information sciences, education, etc.

Each award includes a stipend of up to $18,500, return travel for the award holder and family to the place of tenure, field travel up to $1000, actual training costs, if any, and research funds up to $2000.

Deadline for applications is 15 February 1977. Apply to:Research Associate Awards IDRC, P.O. Box 8500, Ottawa, Ontario.

News

Emergency health nurses

Federal, Provincial and Territorial representatives met on October 6, 7 and 8 at Arnprior, Ontario to report and discuss Emergency Health Services in Canada. Agenda items included: ambulance services; level or training in cardiopulmonary resuscitation in small centers; and, emergency plans in the event of airport disasters such as poisoning or plane crashes.

At present, only three provinces employ nurse consultants for Emergency Health Services — Carolynne Ross (R.N.; B.Sc. (nursing)), nurse consultant, Alberta Emergency Health Services; Julia Roberts (R.N.; Dip. P.H.), consultant, Emergency Health Services, Ontario Ministry of Health; and Carol Beazley (R.N.; B.Sc.N.) nursing and planning officer of Emergency Health Services for the Nova Scotia Department of Public Health. Their duties include:

- reviewing and revising hospital disaster plans and coordinating them with community disaster plans;
- conducting inservice education, seminars and workshops in hospitals about disaster nursing;
- casualty simulation exercises eg. in June, a plane crash simulation exercise was conducted at the Toronto International Airport.

Lorraine Davies, Director of Emergency Health Services on the federal level, is a former nurse consultant for Nova Scotia.

Mandatory registration of federal nurses

Because of the large number of federally employed nurses working in the Northwest Territories, the N.W.T. Registered Nurses' Association has become concerned with the federal policy which does not require current registration status for employees.

The NWTRNA has written to all federal nurses holding current registration in the Association asking them to write to PIPS (Professional Institute of Public Service of Canada) saying that they support mandatory annual registration in the jurisdiction in which they are employed and feel that this issue should be included in current contract negotiations.



Four of the nurses attending the Ontario Occupational Health Nurses Association Conference in Niagara Falls: (from left to right) Laura Raynor from Collingwood Shipyards, Collingwood, Ont.; Dorothy Clarke, Committee Member of Union Carbide, Welland, Ontario; Claire Masters, Committee Member of the Ontario Paper Company in Thorold, Ontario; and Sally MacDonell, General Motors, St. Catharines, Ontario.

"You've come a long way nursie"

Since Olive Bradley became the first industrial nurse in Canada, back in 1908, occupational health nursing has come a long way. Irene Robertson, supervisor of Nursing Service for occupational health nurses with Imperial Oil across Canada, and keynote speaker for the Ontario Occupational Health Nurses' Association October Conference in Niagara Falls, traced the development of the occupational health nurse from a dispenser of bandaids to a professional specialist with a hand in safety, prevention of illness, initiating health programs, home visiting, group teaching, and counselling.

The Ontario association of occupational health nurses has also experienced growth. Marjorie Gohm, president of the Niagara Occupational Health Nurses Association, said that since the association was begun five years ago, the organization has grown to include 613 members. About 300 of these members attended the four-day conference.

Ontario has the only provincial association of occupational health nurses in Canada and guests to the conference came from British Columbia, Alberta, Quebec, Nova Scotia, and the United States. Nurses in attendance were an enthusiastic blend — from industry, business and commerce, hospital health services, community colleges, and the Ontario Ministry of Health. The program developed for the conference had a strong educational emphasis and was prefaced by a one-day workshop offering three content choices. The Ontario Heart Foundation presented a workshop on cardiovascular health in industry, emphasizing risk factors, evaluation procedures, and education for the prevention of cardiovascular incidents. "Foresight Prevents Blindness" presented by the Ontario Division of the C.N.I.B. focused on eye safety, on-the-job hazards to the eyes, and treatment of eye injuries. R.M. Brown of R.M. Brown Consultants in Ottawa, spoke to an enthused and responsive audience about management concepts and interpersonal relationships in the work setting. The three workshops were very practical in nature; they were well-attended and provoked discussion long after the workshop day was over.

The conference itself indicated a wide range of concerns and interests to occupational health nursing as a profession. Laura Legge,Q.C. of Toronto discussed the legal aspects of occupational health nursing in Ontario. Emergency care of patients was included in the program specifically the care of those injuries occurring in work settings.

One of the highlights of the conference was Dr. Ned Cassem's discussion of death, dying and dealing with grief. Dr. Cassem, Associate Professor of Psychiatry at Harvard Medical School and Massachusetts General Hospital in Boston, told of his experiences dealing with dying patients and grieving relatives and brought forward suggestions of what nurses can do to help those who are dying or suffer loss.

The fifth conference of the O.O.H.N.A. was more than an educational update and enjoyable social gathering. The theme of the conference — "You've come a long way, nursie" — brought to light some challenging questions of which perhaps the most challenging was "Where do we go from here?"



Participants in the recent O.O.H.N.A. Conference in October also included: (from left to right) Catherine Napier of the Ontario Paper Company in Thorold, Ontario; Audrey Saary, Beaver Wood Fibre Co. Ltd., Thorold; Claire Masters, Committee Member of the Ontario Paper Company, Thorold; Sally MacDonell, of General Motors in St. Catharines, Ontario; Violet Heard, of Mansfield Denman General Ltd., Welland, Ontario; Lauree Gruber, Port Weller Dry Docks, St. Catharines; Bonnie Reine and Isabelle Glendon of Chrysler Canada in Windsor, Ontario; and Vivian Frankel, of Kellogg-Salada in Rexdale, Ontario.

Self-reliance in health care

Ivan Illich, philosopher, teacher, linguist and author, headed the list of guest speakers at The Professions and Public Policy conference held in Toronto recently. Addressing a group of professionals that included many from the health care field, he took a philosophical look at the health care system in our society and came up with some thought-provoking ideas.

Describing the mid-twentieth century as the Age of Professional Dominance, Illich stated that human beings have come to feel that they must relinquish all control over their well-being, their treatment or non-treatment to the sole judgment of professionals, and that this dependency leads to ill-health. The individual loses his self-reliance with the result that everyone is to some degree a patient who has "needs." Medicine has become so powerful that it can dictate what constitutes a health need for entire classes of people. If more health care really meant improved well-being for the individual, then, perhaps the loss of individual liberty could be rationalized. However, the opposite happens — "medicine engenders helplessness, anguish, infirmity, impairment, pain and outright disease."

Quoting from his latest book, *Limits to Medicine*, Dr. Illich stated, "The prevailing 'religion' is industrialization .... an epoch in which learning is planned, residence standardized, traffic motorized and communication programmed. In such an intensely industrialized society people are conditioned to get things rather than to do them ... They want to be taught, moved, treated or guided rather than to learn, to heal and to find their own way... Healing ceases to be considered the task for the sick. It first becomes the duty of the individual body repairman and then soon changes from a personal service into the output of an anonymous agency."

"The medical establishment has become a major threat to health ..."

Born in Vienna in 1926, Ivan Illich went to the United States in 1951 and now lives and works in Mexico.

Kay Keith directs Public Health study

The Canadian Public Health Association has announced the name of the person who will coordinate the current study on Statement of Qualifications for the Practice of Public Health Nursing. She is Catherine W. (Kay) Keith, formerly of Health and Welfare Canada, Medical Services Branch, regional nursing officer, Northern Region, and nursing officer, Staff Development.

The study is directed towards revision of the existing CPHA "Statement of Functions and Qualification for the Practice of Public Health Nursing in Canada," published in 1966. Work on revision of the original document was begun by a core committee set up in 1975 under the chairmanship of Marie Loyer, Dean of the School of Nursing, University of Ottawa. Other members of the committee included: Olivette Gareau, community health consultant (nursing), Health and Welfare Canada; Laurette Sutton, assistant director at National Office, Victorian Order of Nurses; Jane Henderson, former assistant executive director Canadian Nurses Association; and Ethel Irwin, senior consultant, Public Health Nursing, Health Promotion Branch, Community Services Division, Ontario Ministry of Health.

Specialty scholarship

The International Association for Enterostomal Therapy is accepting applications for its annual scholarship grant from nurses interested in working in this specialty. The scholarship, valued at $1,500, is available to registered nurses with two years recent experience currently employed in a hospital or other related health facility.

The applicant must have a sincere interest in total rehabilitation of the ostomy patient, be utilized in her employment in direct patient care and in staff teaching and be willing to share her expertise and knowledge in the community. Applications are available from: Aileen E. Barer, RNET, chairman, Scholarship Committee, Enterostomal Therapy Centre, Royal Jubilee Hospital, Victoria, B.C. V8R 1J8. Deadline is June 1, 1977.



Recent visitors to CNA House in Ottawa presented a replica of a jug from a Spanish galleon (found in 1692 at Port Royal, Jamaica) to the Canadian Nurses' Association. Margaret Brayton, (left) Executive Secretary of the Commonwealth Nurses' Federation, and Edna Tulloch (right), Executive Secretary of the Caribbean Nurses' Organization, General Secretary of the Professional Institute of Jamaica, and C.N.F. member, look on as CNA executive director. Helen Mussalem (center) admires the vase. The guests to C.N.A. House were in Canada to attend the Dalhousie Conference "The Commonwealth and Non-government Organizations," on October 29, 1976.

Thyroid supplements — cancer risk?

Prolonged use of thyroid supplements seems to be related to an increased risk of breast cancer according to a report in the *Journal of the American Medical Association.*

In the study reported by two doctors in Detroit, it was found that:
— the incidence of breast cancer among patients receiving a thyroid supplement was 12.1 compared with an incidence of 6.2 percent in a control group not taking the supplement
— the likelihood of breast cancer generally increased with the number of years a patient had been on thyroid supplements
— the incidence of breast cancer was higher among those who had never given birth than among those who had borne one or more children.

Commenting on the report, Dr. W.R. Barkley, editor of *JAMA* emphasized that most women taking thyroid supplements did not develop breast cancer. The supplements are so essential for those with inactive or sluggish thyroid glands that physicians should continue to prescribe them when indicated — but with proper counselling to inform patients of risk.

The doctors who conducted the study stated that they were not sure whether the increase was due to deficient activity of the thyroid gland itself or to prolonged use of the medication. They further stated that if their findings were accurate, it would support the contention that the hypothyroid state tends to protect against the development of breast cancer.

News

Representatives of professions study crisis in public confidence

Are the professions really protecting the public interest? Debate and discussion on this and other related questions set the tone for a two-day national conference on The Professions and Public Policy. The meeting was sponsored by the Faculty of Law, University of Toronto, in cooperation with the Ontario Institute for Studies in Education and took place in Toronto, October 15 to 16. Approximately 300 delegates, representing a variety of professions including the health care field, social work, engineering, architecture, teaching and others were in attendance with a sizeable turnout by nurses from B.C., Alberta, Ontario and Quebec. They came together to listen to many eminent speakers discuss the future of the professions in Canada.

The first plenary session was addressed by **The Hon. Claude Castonguay,** Chairman of the Québec Commission of Inquiry on Health and Social Welfare and presently a member of the Anti-inflation Board, on the subject of the future of self-regulation for the professions. He described legislation enacted in 1974 in Québec to govern professional practices and to protect the interests of those receiving professional services. Thirty-eight organizations, known as Professional Corporations, are now recognized by the Professional Code of Québec.

Prior to 1974, professional corporations were granted wide powers without any form of government control over how these powers were used. Although the new laws strongly maintain the principle of self-regulation of the professions, they also call for the appointment of public representatives to the boards of the corporation; the creation of a "professions board" whose main role is to ensure that the professional corporations carry out their functions adequately; and the establishment of criteria for new professional corporations. Another feature of the legislation is to make a distinction between protecting the public interest and defending the professions economic interests. In what he termed a "tentative conclusion," Castonguay stated that the reform of the professions has made steady progress since 1974 in Québec and that it is "accepted, in that it has in no way been called into question." Looking to the future, he suggested that tighter controls over professional incomes might have to be introduced if existing control mechanisms designed to eliminate abuses do not work.

Dr. L. Robillard, president of the Federation of Medical Specialists of Québec, responded to Castonguay's remarks. He suggested that there were not enough members on the Professions Board to properly exercise their functions, and that some groups, such as insurance adjusters who have a significant public impact, escape public control. He also pointed out that it is the role of the professional corporation to establish the quality of work.

Dr. R.E. Olley, chairman of the Board, Consumers' Association of Canada, felt that the system being tried in Québec, although beset with problems, was a "laudable first step," in finding a way to capture the benefits of self-regulation and, at the same time, to keep in touch with the consumers interest.

Reflecting on the question of self-regulation in the United States, Jethro K. Lieberman, legal affairs editor for Business Week, expressed a sceptical view of the self-regulated professions, stating that the power of self-regulation carries with it "the power to transcend the limits of the professional's expertise" especially when they are allowed to police themselves.

Presenting the federal government's viewpoint, **Dr. Sylvia Ostry,** Deputy Minister, Federal Department of Consumer and Corporate Affairs, addressed the second plenary session on the recent decision to extend competition policy to the self-regulating professions.

In a carefully worded document on present government policy, Ostry stated that the focus of concern was the effect of the behavior of professional groups and the cost that this imposes on a society. If market forces were allowed to assert themselves over the professions, she stated, improved performance, efficiency and superior productivity would probably result. This has not been allowed to occur under self-regulation.

Recent federal legislation (Bill C-2) has brought the professions under Canada's Combines Law. This amendment focuses directly on the activities and rules of professional bodies and will try to ensure that these are in the public interest. Activities under current investigation include the restriction on professional advertising, professional fee setting and licensure. Ostry strongly questioned the wisdom of licensure rather than less costly alternatives such as registration or certification since licensing tends to raise the price of professional services without necessarily influencing the quality of services given. She concluded by stating that the greater involvement in the professions by government is a reflection of the change in public attitude towards self-regulation.

Reacting to Dr. Ostry's paper, J.W. Younger, Q.C., vice-president and general counsel of the Steel Company of Canada Ltd., argued in favor of professional self-regulation over government regulation but only as it applies to the 'learned professions' eg. law, medicine and dentistry.

Professor Gorden E. Kaiser, Faculty of Law, U. of T., stressed that there is "a real crisis of confidence in the professions today." He suggested three supply-oriented remedies: certification of specialists; and consumer representation on licencing boards. He warned that if the professions fail to initiate change, then there is no doubt that the government will do so. Professors Lee and Alexandra Benham, Department of Economics, Washington University at St. Louis, heartily endorsed increasing public knowledge of professional services by advertising, and agreed with Ostry's critical comments on licencing.

Eight afternoon workshop sessions dealt with topics such as who qualifies for self-regulation, the use of para-professionals, universal access to professional services, manpower planning, professional unions, continuing competence, discipline and liability and government restraint on professional incomes, and education.

Dr. Dorothy Kergin, Associate Dean of Health Services (Nursing), on the panel for manpower planning, stated that before manpower planning can be carried out in the health field, federal and provincial governments must decide what kind of a health system we want and how much we are willing to pay for it. Until then, the role of professionals such as the nurse-practitioner remains in doubt. Others on the panel questioned the value of manpower planning since, in the past, no action has been taken to alleviate manpower shortages or surpluses. Five years ago, for example, manpower forecasts indicated a surplus of nurses by 1976, according to one Ontario Ministry of Health official. No action was taken since those in the ministry did not believe their own forecast!

Dr. J.F. Mustard, Dean of Health Sciences, McMaster University, speaking on Health Professional Education, touched on many timely problems in the university medical and nursing schools. He stressed that there will be increased attempts by government to control health manpower and the cost of health care. To counteract this, he recommended the establishment of " a public body with the power to review government action and to make public recommendations to which the government must respond within a stipulated period of time if we are to avoid the education and policy development in health and health sciences education being controlled by a small group." He also pointed out that there still has been no clear cut decision from the Ontario Ministry of Health concerning the future of nurse-practitioners.

Both the plenary sessions and the workshops prompted lively discussion from delegates and served to provide a welcome forum for a self-critical look at the professions.



The identification and treatment of "Difficult" Babies

Early Signs of Disruption in Parent-Infant Attachment Bonds

John A.B. Allan

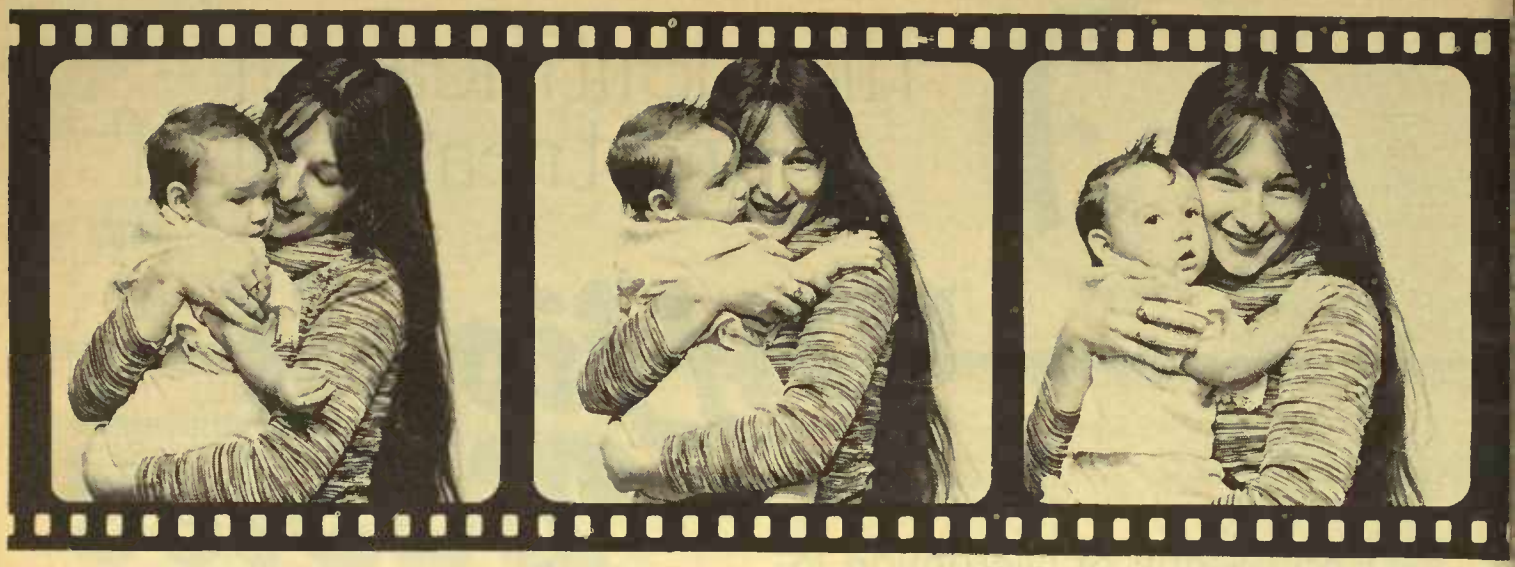
The "difficult" baby can grow into the difficult child unless the early signs of behavior disruption are identified and treated. The best person to spot these warning signals and to aid and educate the new mother in techniques for overcoming them is the public health nurse. In her home visits and pre-and postnatal classes she is the key figure in an important preventive exercise.

Several years ago when I worked as a psychotherapist in a child guidance clinic I was often struck by the way the parents of these older children would refer to their child's behavior as an infant. "Johnny was difficult from the moment he was born," a parent would tell me. Or, "Susan was different from our other babies — she never smiled or let us cuddle her."

It seemed to me that these children — five years old and up — had all shown clear symptoms of their later disturbances in their behavior as tiny infants. They had, in other words, been "difficult" babies. If only it had been possible to identify and help these difficult babies in the first few weeks of their lives how much pain and suffering might have been saved them and their parents.

What is a Difficult Baby?

Difficult babies are babies whose behavior does not lead to the strong attachment bonding to their mothers that is achieved by "normal" babies. Difficult babies may be spotted by disturbances in the five major reflexive actions so important to the development of the child. These behaviors — sucking, crying, clinging, eye-following and smiling — are the biological precursors to many important developmental skills. Their absence, or their presence in only weak form, may be a danger signal that this particular baby and its mother need help.



Mothers can be shown how to reinforce crying by picking up the infant while he is crying, comforting him and holding him until relaxation occurs.

The impairment of these reflexive behaviors in the difficult child show up in these ways:

- *Poor or weak sucking response* which may give rise to subsequent feeding difficulties and a preponderance of negative mother-infant interactions.
- *Poor or weak crying response* which may result in poor babbling and, later, poor speech patterns.
- *Poor or weak clinging response* which may lead to poor physical attachment to the mother and a poor ability to grasp objects.
- *Poor or weak eye-following response* which may give rise to poor eye contact or lead to eye-avoidance behavior.
- *Poor or weak smiling response* which may result in a failure to chortle or laugh in infancy or to receive, enjoy and give pleasure.

These behaviors are initially elicited on an involuntary, reflex basis. They form the biological foundations out of which other attachment behaviors emerge. The failure of an infant to show these behaviors could be perceived as a sign of a weak attachment bond and an indication that special help should be offered to this mother-infant couple.

There are other behaviors a baby manifests that can interfere with the establishment of a satisfactory attachment bond to his mother—behaviors that tend to reflect extremes in muscular tension or arousal levels. Among these I would include:

- the hyperkinetic or excessively "irritable" baby
- the hypotonic, limp or excessively "passive" baby
- the hypertonic, stiff or excessively "rigid" baby

The Normal Baby

Compare the normal baby to the difficult baby described above. The normal baby sucks hungrily and well, cries lustily, clings to his mother when he is picked up, engages in eye-following, and smiles and coos at its parents in later infancy. In short, he is a warm, cuddly, *relaxed* baby — a baby that makes the attachment bond so much easier to establish.

The Importance of the Attachment Bond

An infant's behavior essentially becomes organized and socialized through the parent-child attachment bond. It is through this relationship that an infant's energy becomes regulated, channelled and transformed into socialized behavior. As a baby grows its reflexes mature, become stronger and more clearly defined, and then go through a period of disorganization; afterwards the behaviors return on a voluntary basis.

A very important stage of attachment in our species spans the period from birth to three years. During this period a number of important developmental sequences occur. Through their interaction with their baby, parents play a critical role in helping him discharge his energy into appropriate socialized behavior. A specific attachment bond grows between parents and child that provides the child with feelings of trust and security. His first imitative behaviors gradually change to a movement away from his parents into play with other children and interaction with other adults.

The reverse pattern — the weak or broken attachment bond characteristic of the difficult child — also affects the organization of behavior, but it results in an unregulated and poorly discharged flow of energy, the internalization of feelings of distrust and uncertainty, and a preponderance of avoidance and negative behavior towards parents. It also leads to a failure to move into successful play with children and a later reliance on maladaptive attention-seeking behavior to establish primitive forms of attachment to adults.

In other words, attachment is necessary for growth and normal behavior. *Disturbed behavior then can be viewed as reflecting a break in the parent-child attachment bond.* This concept has important implications regarding prevention, identification and treatment of disturbed behavior in children. In essence, it means that where repeated patterns of disturbed behavior in young children are observed, the question needs to be asked: What went wrong in this parent-child attachment bond? How can it be strengthened or re-established? How can this mother (or father) and child be helped to come together and enjoy each other?

The Role of the Public Health Nurse

The difficult baby causes the mother to feel inadequate about her mothering capacities. What is needed in these cases is the awareness by the professional of the difficulties this baby could cause the mother, and the provision (or opportunity) for professional help and guidance *until a satisfactory and pleasurable mother-infant attachment bond is established.* In some cases this may mean daily or weekly personal help for two or three months. *The professional best equipped to deal with these questions is the public health nurse during her postnatal home visits and at weekly child care centers.*

In some cases, just making parents aware of the importance of certain attachment behaviors will lead to parental reinforcement of these responses. In other cases parents might have to be shown ways of holding or interacting to stimulate certain behaviors or to overcome unusually strong muscular tensions in their children. The public health nurse during her pre-and postnatal classes and in her home visits could keep parents informed about possible "difficult" behaviors and teach them techniques for overcoming or at least ameliorating them. I suggest the following as being the most important:

1. A discussion of the attachment bond and the implications this has for the socialization of our children. Parents should be told the age at which a baby will show specific attachment to its mother and the effects this bond will have on exploration and learning.

2. An elaboration of the five major behaviors that facilitate attachment and the ways these behaviors can be reinforced:

- The failure to establish a strong sucking behavior can lead first to considerable tension between mother and child and later into other feeding difficulties. Some mothers need considerable support in order to establish a mutually satisfying relationship. The public health nurse might encourage the mother to let her infant take the initiative in when he wants to feed, how he wants to feed and, later, what he wants to eat.
- Crying facilitates attachment in that it frequently brings mother and, consequently, comfort and relief from distress. Mothers can be shown how to reinforce crying by picking up the infant while he is crying, comforting him and holding him until relaxation occurs. Mothers need to know that it is important to reward the infant's assertive behavior and let him know (on a non-verbal level) that he has some say over his life and that through his actions he can control his world and bring relief from discomfort.
- Mothers should be taught the importance of eye-following and eye contact. The amount of reinforcement a mother gives her baby will directly affect his eye contact and eye-following behavior.

Mothers have observed that their infants spend considerable time searching and scanning their faces, usually with the result that eye contact is established. When this happens, the infant frequently breaks into a smile response which seems to provide a pleasant sensation of tension reduction.

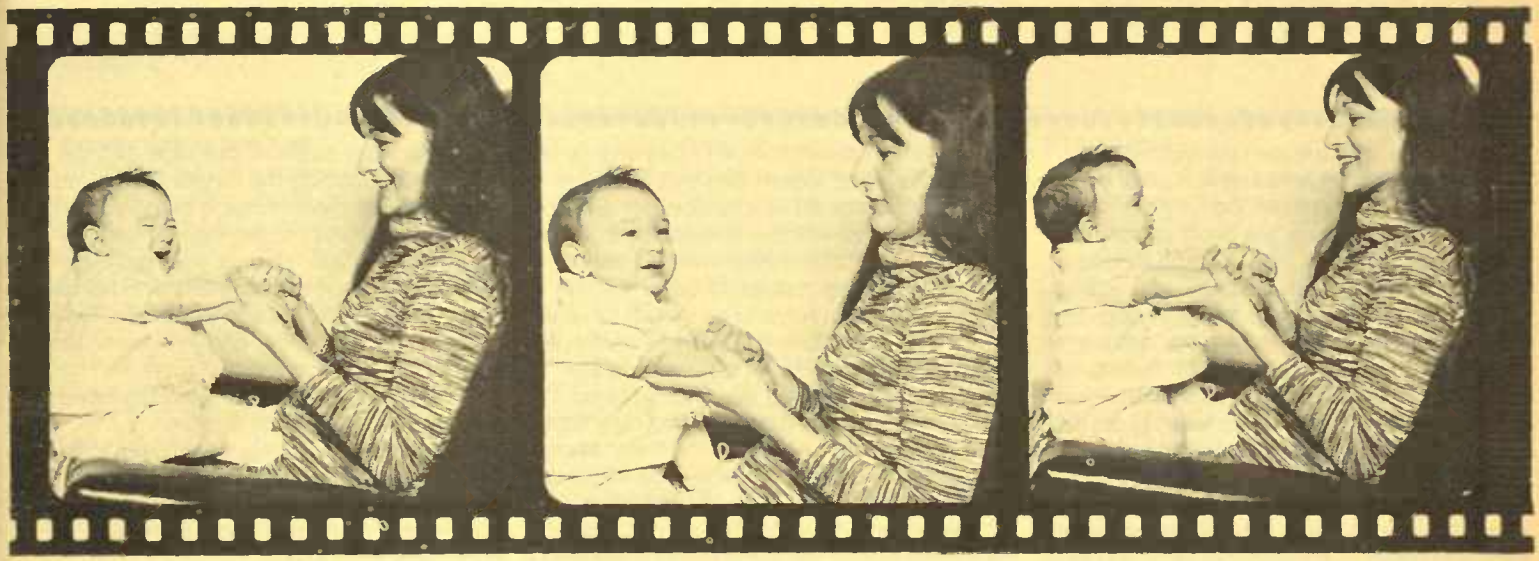
Eye-following and contact seems to orientate the infant to his mother's face and, therefore, is important in the development of the mother-infant bond.

The clinging response is first produced reflexively but comes under voluntary control at about six weeks of age. This response can be reinforced by giving the baby opportunities for practice, such as placing a finger in the palm of a baby's hand so he can grip it and then tightening the finger slightly so that a pleasant tensional relationship is established and maintained.

Mothers can help strengthen clinging by giving their babies ample opportunity for practice. It is important to teach a mother how to hold her baby comfortably so that his head, neck and back are supported and he is not held too tightly.

- Mothers can also be shown how to encourage smiling by various sensory stimuli. They should be told that picking up an infant, smiling, talking to him and patting him all reinforce smiling.

3. An explanation of how proper holding can help the excessively ***rigid, irritable*** or ***passive*** baby to relax is especially important. These babies are the ones I would describe as unusually difficult babies and I have found two approaches helpful. One is for the parents to be helped to learn what "works" with this baby, what interactions satisfy him, what games he likes to play. These can all be used to reinforce his positive behavior. The other approach entails teaching the parents special holding procedures that are designed to lower or raise the level of arousal, or to reduce muscular tension so that attachment is facilitated. I think these holding techniques are very important and I have described them in detail here:



Proper holding blocks or prevents the random discharge of energy through body movements; it forces energy to move even when locked into stiff tensional posture and it results in a peak experience of rage and sobbing which is followed by a period of relaxation. Here, the mother, with the baby facing her on her lap, demonstrates a fluid but firm grip on the baby's arms and hands.

If the child is in great distress, the mother may place the child sideways across her lap with one shoulder tucked up against the mother. In this case, the mother places her outside hand on one arm and hand of the baby, and the other on the child's lower legs and feet.

- ***The Irritable Baby*** — This term applies to the baby who constantly whines, who will not cuddle or relax on the lap, who over-responds to most stimulation and who shows excessive fear or crying (usually without tears). I am not referring to the "colicky" baby but to conditions of irritability that persist well beyond the third month and to states that do not respond to normal comforting procedures. A mother can be taught to hold her irritable, tense and "whiney" baby fluidly yet firmly in her arms or on her lap. It is important that she hold both the baby's arms and hands in her hands and not disengage them until the baby is relaxed. The holding must be of a very sensitive nature; if



The mother should spend five or ten minutes holding the infant up (lifting him up underneath both arms and keeping his head slightly forward) moving him up and down and back and forth and smiling into his face

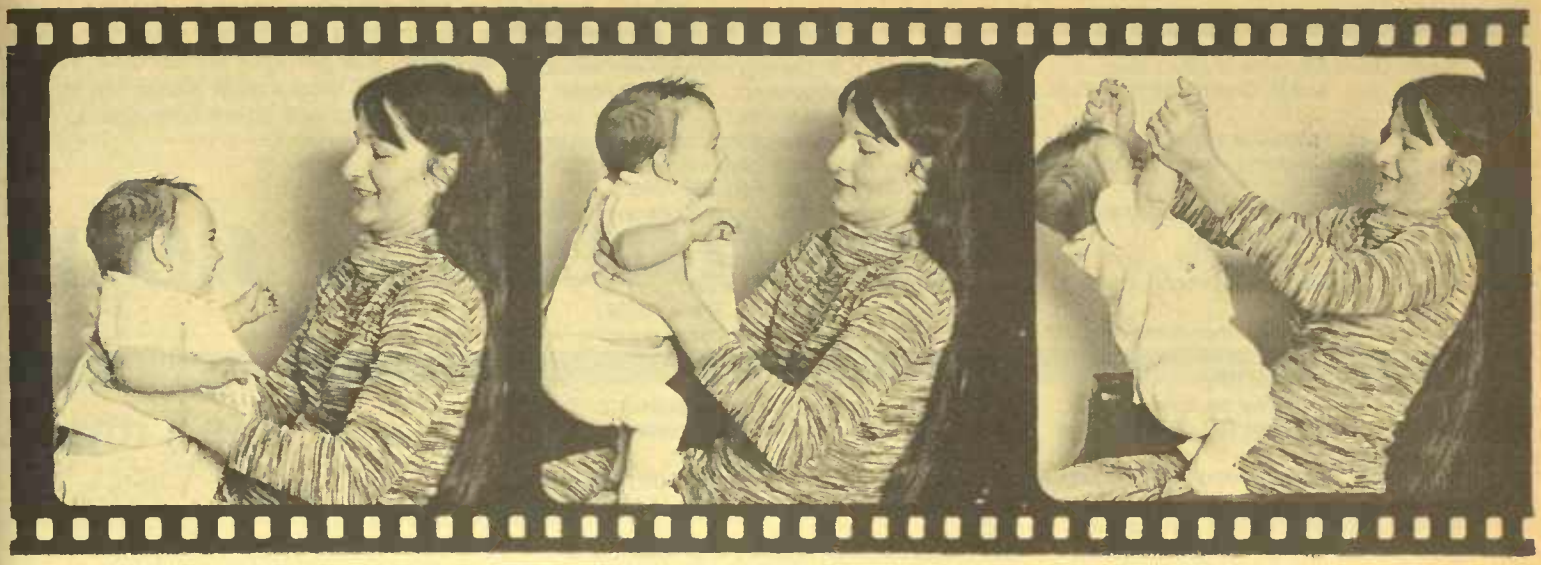
the baby stiffens and tenses the mother gently increases her tactile pressure to a point equal to, but then slightly greater than, the child's so that the arms and legs will bend at the joints into a relaxed position. This will probably result in a rage response from the baby, followed by more extension of the limbs and stiffening. The mother must be taught to give her baby a moveable barrier to rage against, that is, her hands and arms do *not* act as a straitjacket type of restraint, but are firm enough to provide some flexible opposition. After a few minutes of stiffening and rage reaction, the baby should begin to relax muscular tension and start to sob. At this point the mother should relax her hold and begin to comfort the baby and to encourage the sobbing. This can be achieved through tone of voice and by tilting his chin forward onto his chest. After sobbing, a baby may fall asleep or lie contentedly in the mother's arms. In some cases, it may take several cycles of the rage-sobbing-relaxation pattern before prolonged relaxation is achieved.

What this method tries to effect is a transformation of the way an infant discharges impulses or energy. Proper holding blocks or prevents the random discharge of energy through body movements, it forces energy to move even when locked into stiff tensional posture and it results in a peak experience of rage and sobbing which is followed by a period of relaxation. Some mothers will be able to follow this holding procedure quite readily while others might have to be shown several times. One nurse told me that she conveyed holding instructions to a distraught mother over the telephone and when she checked back later she found it had worked very well.

•***The Rigid Baby*** — This is the baby whose muscular tonus is characterized by states of unusual rigidity or stiffness. These babies are not comfortable to hold, they do not mold to the mother's body nor do they relax when held but tend to remain stiff or fight free. If these responses are allowed to continue the child may, later on in childhood, find himself locked into a pattern of response where he is unable to comply and where he attempts always to control and manipulate his parents. Mothers of these infants should be shown that by proper holding it becomes possible to transform or reduce these unusually stiff or rigid muscular states. With some babies this can be done simply by stimulating the smile and laughter (chortling) responses, as these rapidly reduce tension. The mother should be instructed to spend five or ten minutes holding the infant up (lifting him up underneath both arms and keeping his head slightly forward) moving him up and down and back and forth and smiling into his face. Most babies cannot resist this stimulation and even in the midst of a rage reaction they will start to smile and chortle although in extreme cases of muscular tension the release that comes is only very temporary. In these cases the mother should be taught to move the baby's body about like an accordion, that is, the mother should extend and flex the trunk and limbs gently and rhythmically. This will initially result in increased dorsal arching and extension responses until the infant rages and sobs. The stronger the rage and the deeper the sobbing the longer the period of relaxed attachment. What is being striven for here is an open-coupled system between mother and infant. Usually the rigid baby is locked into a "closed" system with his own body — hands gripped together and legs crossed. Through time and with persistence the baby will become more sociable, more smiling and more "cuddly" and the need for this type of holding will diminish.

Mothers should also be advised to lie the stiff and rigid baby on his stomach. In this way his tension and energy can be used to push against the mattress in lifting his head, shoulders and trunk.

•***The Passive Baby*** — These infants tend to emit weak clinging responses and also fail to mold or cuddle to the mother's body. They prefer lying alone in their crib to being with people and they tend to under-react to stimuli. This lack of social attachment during the first year of life leaves their energy relatively unregulated. They seem to be "perfect" babies until they start to crawl or walk at which time the lack of prior learning and control becomes apparent. The mother of one "passive baby" described her toddler as a "little hurricane." Mothers should be warned that "perfect" babies need additional input and stimulation and that it may be detrimental to leave them lying in their cribs for long periods. The lack of crying and their quietness should be viewed as a cue for attention. They need to be carried about by parents so that they can receive an abundance of tactile and kinesthetic sensations. These sensations will greatly help to change the state of passivity into one of lively and alert activity and set the stage for mutually satisfying interactions.



The mother should be taught to move the baby's body about like an accordion, that is, she should extend and flex the trunk and limbs gently and rhythmically.

Prevention is the Key

The public health nurse is in a position to advise parents of the disturbances and techniques described above. The problem of identifying the difficult child might also be helped if "difficult baby clinics" were held at hospitals, public health or mental health clinics, so that parents who are worried about their baby's behavior could drop in, talk over their fears and receive some practical help.

If many of the behavior problems encountered when a child is five or six are rooted in their behavior as infants, it becomes clear that the detection and modification of these unsuitable behaviors is of the utmost importance. Of course later behavioral disturbances do not all stem from the difficult baby. The trauma of a parent's death, a serious illness or hospitalization, the birth of a new baby in the family or even the parents inability to cope may all affect the later behavior of a child. Likewise, allergic reactions in infancy (especially to milk and eggs) can have a devastating effect on behavior. Obviously, holding is not indicated here but a change in diet.

But the difficult baby sends out clear signals to those experienced in infant behavior, and with help and support the new mother may be able to ameliorate her baby's condition. Through her close contact with the new mother the public health nurse is in a position to play a vital teaching role. She can warn parents of danger signals and show them how they can help improve their infant's behavior so that it will not interfere with the forging of the attachment bond, so important to the development of the child's relationship with his parents, his peers and his world.

Sympathetic and careful guiding in the early weeks and months of an infant's life may make the difference between a baby who builds a satisfying relationship with his parents — leading to a healthy and successful "coping" with life in later years — and the child who is plagued with the emotional disturbances associated with weak attachment bonding.

This article is based on a paper presented at the Inter-Agency Refresher Course for Public Health Nursing Supervising Nurses, Vancouver General Hospital, December 1973.

Many of the ideas expressed in this paper stem directly from the author's training with Dr. Robert W. Zaslow, of the Psychology Department, California State University at San Jose, California. The author is indebted to Dr. Zaslow for making him aware of the importance of the attachment relationship and of the possibility of the reduction and transformation of maladaptive levels of arousal and muscular states by the use of holding.

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Mothers can reinforce the clinging response by giving the baby opportunities for practice, such as placing a finger in the palm of a baby's hand so he can grip it and then tightening the finger slightly.

Learning is a two-way street for the nursing students and school-age youngsters involved in this experiment. For the children, there's the chance to learn more about keeping healthy. And for the aspiring R.N., there is the opportunity to change her public image from "the person who hurst you" to "The person who helps you and wants to be your friend."

Idea Exchange

Health Helpers

Debbie Burke, Janet Horvath, Barbara MacNeill, Mary Anne Waddell

Two years ago, a kindergarten teacher contacted the Cambridge Nursing Division of Conestoga College to ask if some student nurses could come to her class. They were to portray 'health helpers' during a week the kindergarten teacher had devoted to this topic. As a result of this call, a whole new pediatric community experience evolved at our school of nursing, and many nursing students have since had the opportunity to interpret the nurse's role to school children from nursery school to grade three.

School presentations, organized and planned by nursing students, were usually based on the format used for the pediatric preop classes at South Waterloo Memorial Hospital, our clinical facility. The pediatric staff there were most helpful in recommending methodology, suggesting audiovisual aids, and lending books or pictures to the students for their presentation.

Two students shared the teaching experience, setting their own objectives, and using their own ideas in planning a program. For example, some objectives drawn up by students instructing a grade two class included:

- to clarify the children's perception of the hospital, health team members, and hospital equipment,
- to learn to teach seven and eight-year-olds about health in an understandable way,
- to gain insight into assisting children of this age to adjust to the hospital environment, so that hospitalization is less traumatic,
- to gain insight into the child's perception of the hospital, health team, and separation from his family,
- to convey an image of the nurse as an approachable and helping member of the health team.

These objectives indicate the two-way nature of the learning experience, — both the child and the student nurse had something to gain from the project.

Student nurses arranged and organized their own experience, independently contacting the school principal and the specific teacher involved in the project. This encouraged the student to use her own initiative and taught her about lines of communication and organization. Often the students arranged for one student to wear a uniform to the school presentation while the other student wore street clothes. This demonstrated to the children that not all nurses wear uniforms.

It was left to the students to decide how they wished to introduce their topic. A grade two class was found to respond to a discussion about reasons for going to the hospital with surprising contributions. Preschool groups responded better initially to a display of hospital-related equipment that they could ask questions about or play with.

A play session gave the children an opportunity to see how hospital equipment is used. They pretended to give needles to the nurses and to each other. They had the nurses look into their eyes and ears and take their blood pressures. One little boy was very anxious about having his blood pressure taken until he was given the opportunity to pump the cuff himself. Student nurses were given the opportunity to use their initiative and creativity in explaining the equipment, and in settling any arguments that arose during the children's play.

Story books and posters were used as part of the students' presentation. Depending upon the age group of the children, the student nurse read a book like "Curious George Goes to Hospital" or provided narration to a series of posters depicting a child's admission to hospital. The hospital play therapist lent posters to the student nurses for specific presentations. During the stories or poster narration, the children were invited to ask questions, and the nurses received feedback about the children's level of awareness.

Art projects usually followed the nurses' presentation — these ranged from drawings to making nurses' caps and stethoscopes. The artwork also reflected the way in which the child perceived the experience of hospitalization. Often the drawings depicted hospital staff in gargantuan proportion to tiny hospitalized patients.

After their school visit, each nursing student was required to write a report that included objectives (whether or not they were realized) and recommendations for change. They evaluated the teaching project as a learning experience and applied what they had learned to caring for a hospitalized child.

Some of the observations made by the student nurses as a result of their teaching experience included:

- Valuable feedback from the children could be drawn out through the use of stories and posters. The children's responses to stories gave the students an opportunity to reinforce or clarify certain points.
- Initially, the children addressed more questions about hospital equipment to the student dressed in her nurse's uniform. As the nurse in street clothes demonstrated her ability, she was approached more readily by the children.
- Play therapy proved a valuable agent in reducing the children's anxiety — they discovered that their own friends could peer out from behind disposable masks.

This article was a combined effort on the part of four second year students during their pediatric clinical experience. All were members of the 1976 and final graduating class of the Cambridge Nursing Division of Conestoga College of Applied Arts and Technology.

NEW CONCEPTS IN INFANT NUTRITION



Emily Rozee

Breast? Bottle? Spoon? Table foods? Vitamins? When? Why? How? These are important questions for the new mother who is usually bombarded by suggestions and criticism from well-meaning friends and neighbors, not to mention professional advice from her doctor and community health nurse.

In the face of so much — often conflicting — advice, it is hardly surprising that some mothers adopt feeding practices that are not conducive to the optimum growth and development of their baby.

As a public health nurse working in a northern community, it sometimes seems to me that the job we are least prepared for in this day of the nuclear family is parenthood.

Many of the parents who attend our weekly child health conferences admit to being at a complete loss when it comes to introducing their offspring to solid foods. Others follow their own instincts, often to the detriment of the child's health and sometimes with amusing results. One couple, obviously satisfied with their job of parenting, let their baby dictate what she would or would not eat. At five months, her diet consisted solely of milk and fruit.

Another, whose degree of pride and pleasure in his young son was obvious, told me that his three-month old baby was eating table foods already. When I enquired about how he prepared the foods the father stated proudly that he chewed the food first himself and then fed it to the baby.

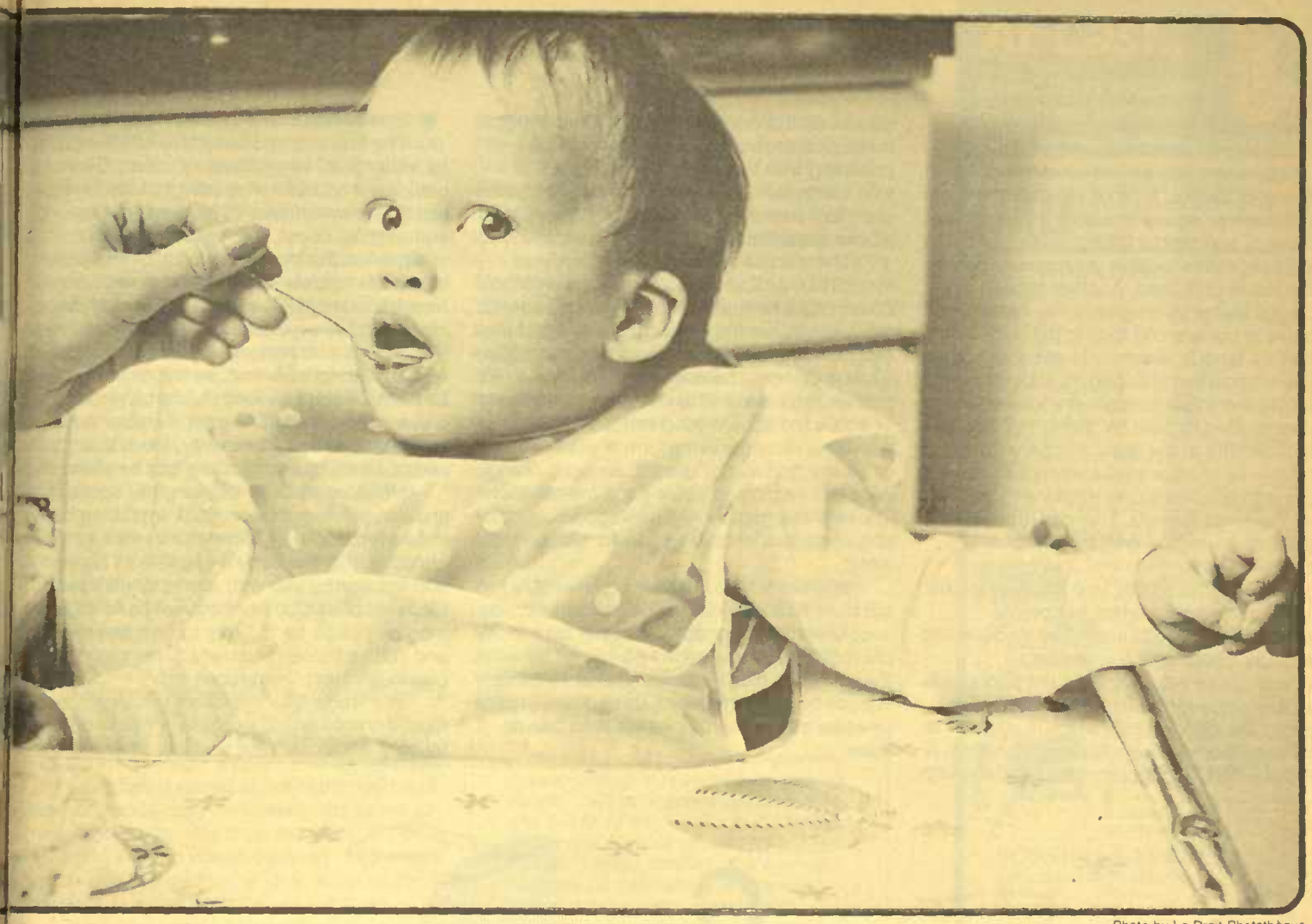


Photo by Le Droit Photothèque

Breast or bottle?

Uncertainty about what to feed, when and how, precedes the first hunger cries of the newborn. The relative merits of breast feeding, as compared to bottle feeding, have been hotly debated for many years. One agency that has recently come out in favor of breast feeding, if the mother is physically and emotionally able to nurse her child, is the Metropolitan Vancouver Department of Health in British Columbia. The Department cites these reasons:

- Breast milk has the correct ratio of carbohydrates, protein, and fat, suited to the digestive system of a human infant. (Cow's milk has the correct ratio for a baby calf).
- Breast milk is more convenient.
- Breast milk is sterile.
- Breast milk is cheaper.
- When a mother breast feeds her infant, she has no visual idea in terms of ounces how much her baby has eaten. She assumes he is satisfied after he has nursed for a reasonable length of time. She does not try to urge him to "finish" as she might if there were an ounce or so remaining in the bottle. Therefore, there is less anxiety, and less chance of the baby being over-fed. Overfeeding in the first months of life shows high correlation to obesity in later life.
- Breast milk possibly provides antibody protection for the infant.
- Breast feeding speeds up involution of the uterus.

For the mother who is unable to nurse her child, there are a variety of commercial milk formulas available that approximate breast milk very closely. An adequate formula can also be made using evaporated milk, although it must be altered by adding water and a form of sugar to provide the infant with the proper ratio of protein, fat, and carbohydrates. These formulas are especially good for mothers who have certain illnesses or have to take certain drugs, or who simply do not wish to breast feed. They are also very handy for the working mother who wishes to breast feed — a bottle can be given at noon if she cannot be there to feed her baby. However, breast milk can also be expressed and stored in the refrigerator for this same purpose.

By the age of seven or eight months, the natural iron stores that the baby was born with are depleted. Unless this supply of iron is replenished by the addition to the diet of cereals, meat, or egg yolk, there is a definite danger of anemia developing. When I see an overweight, pale, listless baby I suspect that this is a baby who is receiving only cow's milk, with few solid foods added to his diet. If he is receiving any solids at all, they are usually in the form of mashed potatoes and gravy.

At the other end of the scale, are the mothers who give their babies a vitamin enriched formula to which they add vitamin drops, thus over-dosing with unnecessary extra vitamins.

Introducing solids

For a long time now, solids have been introduced as early as two weeks, usually in the form of cereal. A more recent concept is the idea of waiting until the baby is three to four months of age before giving solids, as the infant's digestive system is unable to handle these foods until then. Another reason for waiting is that physiologically, the infant is not capable of transferring food to the back of the mouth by tongue action until about this age. Salivary secretion also begins about this time enabling the infant to taste dry foods. It is recommended to start by giving the three month old one of the least allergenic forms of cereal — i.e. rice or soybean cereal, and to begin with one teaspoon mixed with a little boiled water or formula. This can gradually be increased in amount and thickness as the baby tolerates it.

Many mothers think that if they wait until he is three or four months old before introducing solid foods they must be depriving their baby of some of the essential nourishment he needs. In fact, the opposite is the case since too early addition of solids reduces the intake of milk which is superior to solid baby foods in the nutrients it contains. A well-balanced formula provides the baby with almost all the nutrients he needs for the first three or four months of life. Breast milk, providing that the mother is eating a well-balanced diet and that the baby receives sufficient volume of milk, also supplies almost all the essentials for growth.

The exception to this general rule is Vitamin D. Almost all homogenized milk and commercial formulas have been fortified with this vitamin but the breast fed baby and the baby whose formula does *not* contain added Vitamin D should have it added to their diet. All babies, regardless of whether they are breast or bottle fed should be given a Vitamin C supplement, either in the form of vitamin drops or by the addition of diluted, strained orange juice or vitaminized apple juice to their diet. These juices may be given by spoon or bottle and, if diluted, should be mixed with boiled water.

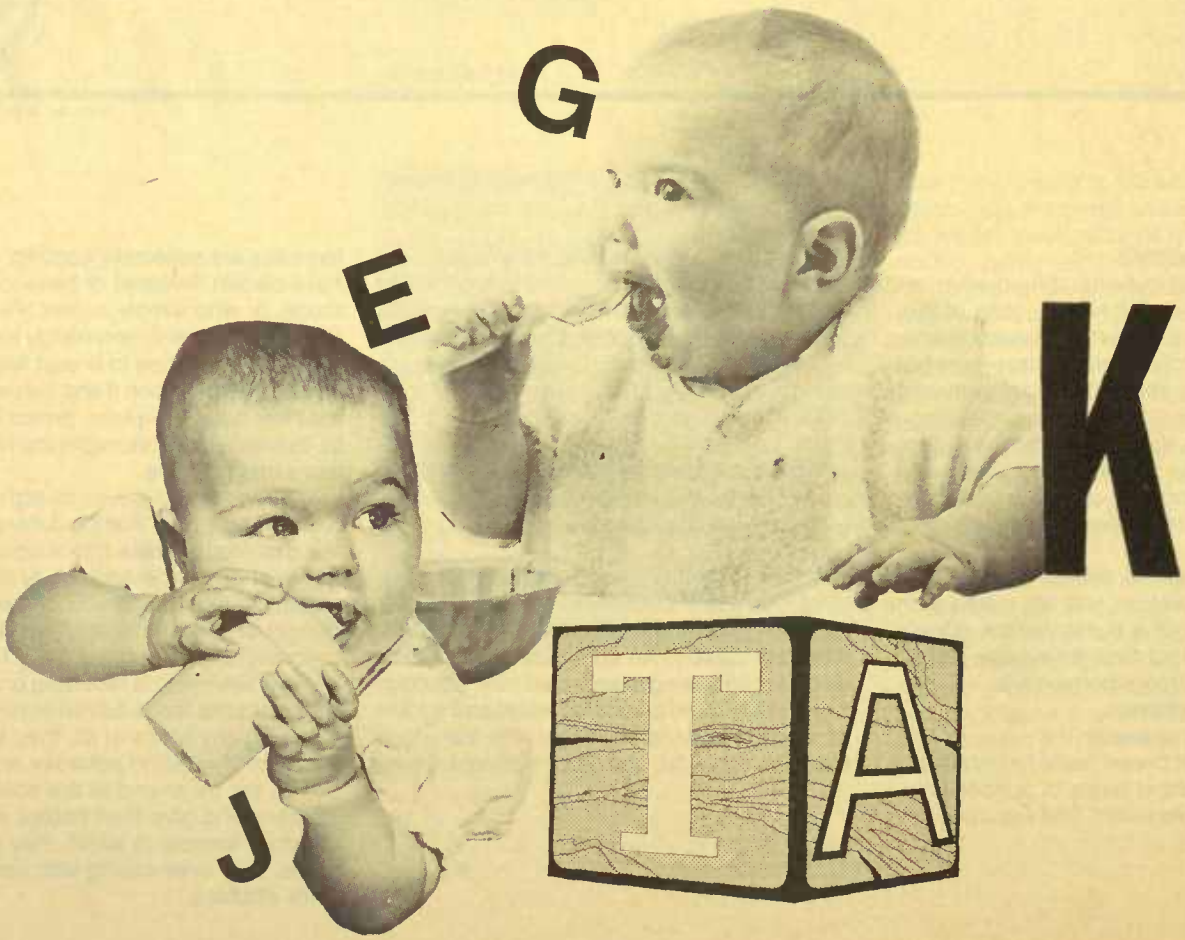
In areas where the local water supply has not been fluoridated, the addition of a fluoride supplement to the baby's diet will help to prevent decay in the teeth now being formed in the gums. Authorities recommend that this fluoride be given in several small doses in juice or water during the day rather than one daily dose.

Sweet taste of success

The first strained baby food to offer might be either fruit, vegetables, or meat. Often babies will accept fruit readily, but having first tasted the sweetness of fruit, will not be enthusiastic about the "bland" taste of vegetables. For this reason, it is often a better idea to start slowly with a variety of vegetables. New foods, regardless of the type, should be introduced when the infant is well-rested and feeling well and hungry. If you satisfy his hunger with formula first, he will not be hungry for solids. Each new food should be given over a five to seven day test period before adding another new food. In this way, foods that may cause an allergenic reaction can be avoided.

Mixtures such as dinners and soups should be avoided when first introducing baby to new foods. It is a good idea however, to take advantage of the baby's appetite at his age and familiarize him with as many different foods as possible. At about seven to eight months of age he is likely to become finicky and refuse those foods which he hasn't previously been introduced to.

With regard to the infant refusing a new food, it is wise to wait a couple of weeks before trying it a second time. Babies, after all, are



individuals and have a right to their likes and dislikes. Mothers should know that this attitude is to be expected, especially in the beginning when introducing the new taste and feel of solids, and should not be intimidated by it. All babies react to solids in a "negative-appearing" way at first, although, this reaction may just be surprise at the taste and feel of solid food, and the fact that it does not taste remotely like milk. The parent, then, should not abandon the attempt to introduce a new food, but should wait for a week or so and then try again. Indefinite postponement, however, solidifies the infant's resistance to change and should be avoided. Gentle persuasion usually does the trick, and both mother and infant have the satisfaction of having crossed another bridge. If the child continues to refuse an item, it should then be assumed that he definitely does not like it, and the parent should not continue to try to get the child to "like" it. Like the adult, he has his preferences.

◉ Growing up

Another question often asked by parents is when to switch from formula to homogenized milk. It is now recommended that the introduction of cow's milk be deferred until the infant is eating about eight ounces of strained foods daily — usually, about six to nine months. By this time, the baby will be obtaining enough vitamins and iron from these foods to make up for the loss of the extra nutrients in commercial infant formulas.

When the baby's first teeth begin to come through, or when he begins to make biting or chewing movements, the baby is ready for his introduction to lumpy foods. These may be commercial "Junior" foods, or mashed table foods. Often, table foods are a better choice, not only because they are less expensive, but also because they serve as an introduction to the foods he will soon be eating regularly. The mother who chooses foods that she has prepared has the satisfaction of knowing exactly what they contain and can make sure that no unnecessary fillers, spices, salt or sugar are added. Babies will readily accept foods that do not contain unnecessary salt or sugar if they have not acquired a taste for these additives.

The mother who has successfully maneuvered her way through the obstacles of the first few months of feeding her baby can now afford to relax in the knowledge that she has successfully laid the foundation for a lifetime of good eating habits.

Emily Rozee is a Public Health Nurse working with the Skeena Health Unit in Terrace, B.C. She is a graduate of Sydney City Hospital School of Nursing in Sydney, N.S. and received her diploma in Public Health Nursing from Dalhousie University. After graduation, she worked for the Department of Preventive Medicine as a Public Health Nurse at the Victoria General Hospital in Halifax, N.S., before deciding to travel across Canada. The article grew out of the feeling she had that too many parents are confused or lack basic knowledge about the growth and development of their child.

References

1 Blake, Florence G. *Nursing care of children,* by ... et al. Philadelphia, Lippincott, 1976.

2 Wolczuk, Patricia D. *Infant nutrition; current teaching concepts.* Vancouver, B.C., Vancouver Branch, Dept. of Health, 1974.

3 *Infant nutrition.* Draft. Vancouver, B.C., Vancouver Branch, Dept of Health, 1974.

A three-hour closed-circuit symposium, "Infant Nutrition: A Foundation for Lasting Health?" will be televised simultaneously and live to 19 major cities in the United States and Canada on March 23, 1977. The symposium consists of graphically supported presentations and ninety minutes of questions and answers between the audience and the panel. Canadian locations are Toronto, Vancouver and Montreal (where the program will be broadcast in both French and English).

A professor will be available at each location to moderate the program and coordinate the question-and-answer sessions. The program is sponsored by The University of Iowa College of Medicine, in cooperation with the National Heart, Lung and Blood Institute; the National Kidney Foundation; and the Committee on Atherosclerosis and Hypertension in Childhood, Council on Cardiovascular Disease in the Young of the American Heart Association.

At Last...



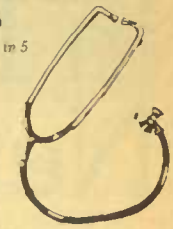
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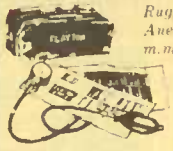
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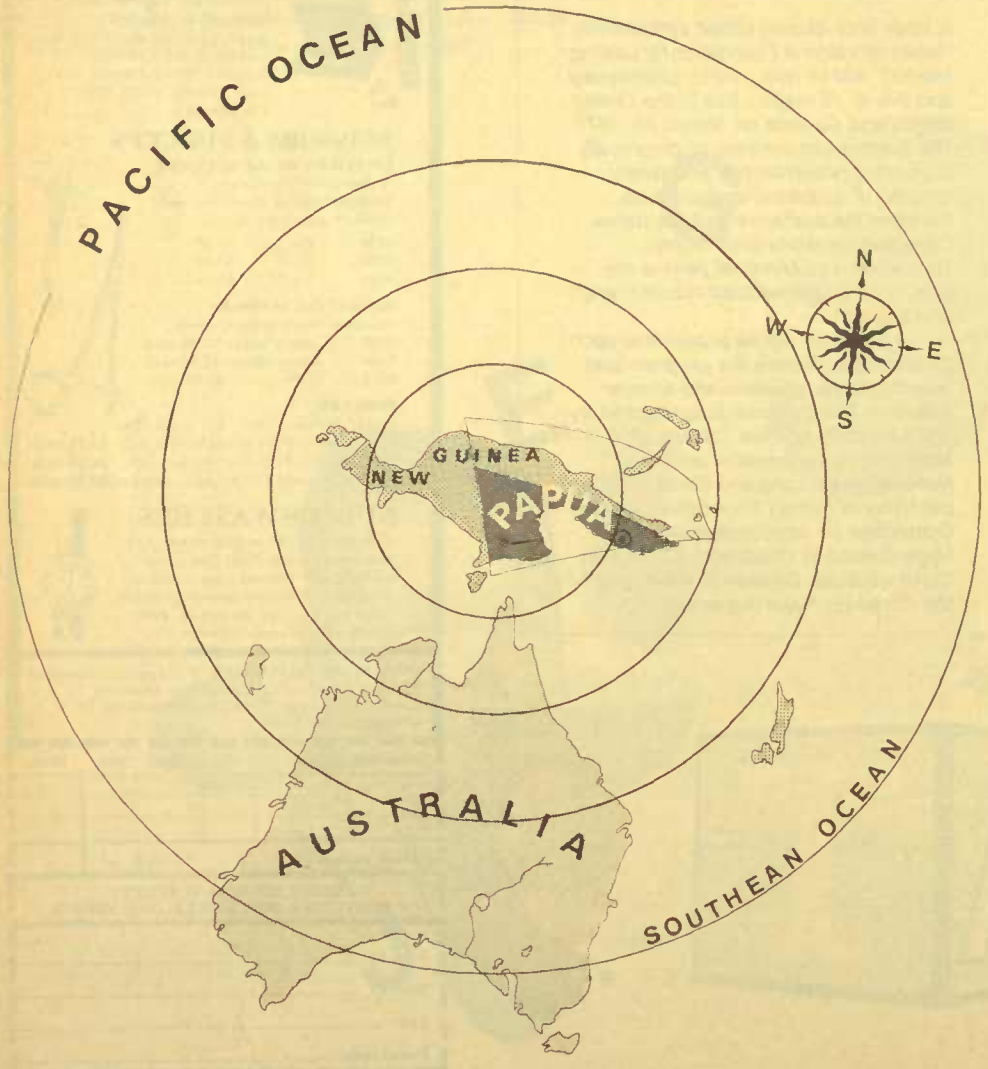
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An unusual **obstetrical case** in Papua New Guinea

Dolores Hall

Madang General Hospital is a 300-bed center situated in a coastal town on the tropical island of Papua New Guinea. It is the base hospital for Madang, a province with a population of about 200,000 people scattered throughout 17,880 square kilometers. People with medical problems that prove too difficult or complicated to be handled at rural health centers are transferred to Madang General Hospital for treatment. Ombu Mundi was one such person.



Ombu Mundi is a 38-year-old woman from Aranam village in the subprovince of Bundi in Papua New Guinea. On the morning of April 11, 1976, in her own village, Ombru delivered a premature stillborn infant, a breech birth. She went to the Bundi health center because she had not delivered the placenta. The health worker there examined her and found that there was still a live fetus in utero, so he arranged transportation to take Ombu to Madang General Hospital. She arrived at the hospital some three days later in no immediate distress.

Ombu was para 5, gravida 6. Her initial physical examination at the hospital revealed:

- BP 100/60
- Chest
  — clear
- CVS
  — no acute distress
- Abdomen
  — 32/40 weeks gestation
  — fetus in high vertex presentation
  — fetal heartbeat regular
- Pelvic
  — old cord of first twin still in place

Ombu was to remain at Madang General Hospital for over a month. The following describes her clinical course and treatment regime at the hospital:

April 14, 1976
Initially the prescribed treatment was concerned with induction of labor, antibiotic therapy, and antimalarial treatment.

- Artifical rupture of the membranes was attempted unsuccessfully as the patient's cervix and vertex were high, and pus was draining from her vagina.
- The first attempt was made at induction of labor. Syntocinon 2 and 1/2 units in 1000 cc 5% D/W was begun at 10 gtt/min and increased q 15 minutes by 10 gtt, up to a maximum of 60 gtt/min. The doctor was then notified that Ombu was not yet in established labor. Medical induction of labor was therefore discontinued, but intravenous fluids were continued as ordered.



The doctor in charge of the obstetrical ward at this time was Dr. Greg O'Connell, a CUSO volunteer. The nurse in charge of the obstetrical ward is Sister A. Toyola from Samarai, Milne Bay Province, Papua New Guinea.

The photo on the left shows: (left to right) Sister Toyola, Ombu and her baby, and B. Munuju, the first male nurse-midwife in Papua New Guinea.

- Antibiotic therapy was initiated to combat Ombu's infection. She was given Crystapen 2,000,000 units intravenously q6h, and Chloramphenical 750 mg IV q6h.
- Chloroquine was ordered — 3 tabs (750 mg) stat, and daily for two days — as antimalarial treatment.

April 15

- Lab results indicated that Ombu's hemoglobin was only 6.4gm%. She was therefore grouped and crossmatched and given 2 units of whole blood.
- Medical induction of labor was attempted a second time, using Syntocinon 10 units in 1000 cc 5% D/W at 10 gtt/min and increasing to 60 gtt/min. Ombu did not respond to this treatment.

April 16

- Ombu was still not in labor, but showed no signs of distress. She was allowed to rest for 24 hours. Intravenous fluids were continued for the administration of antibiotics.

April 17

- A third attempt to induce labor met with no success.

April 18

- A lower uterine segment cesarean section was done under general anesthesia, and a live male infant was extracted using Wrigley's forceps. There was little evidence of intra-uterine infection. Because there was no previous consent obtained from her husband, sterilization was not performed. The wound was closed in two layers.
- Post-operatively, intravenous fluids were continued along with antibiotic therapy. Ombu was given Pethidine 50 mg q4-6h for incisional discomfort. Her vital signs were observed and recorded, and proved stable.

April 19

- Ombu's ambulation was begun to prevent the development of postoperative complications.
- Medications were ordered and given as follows:

Imferon 5 ml IM daily x 3 days
Ferrous Sulfate 300 mg p.o. twice daily
Folic Acid 5 mg p.o. daily
Vitamin C 50 mg p.o. daily
Vitamin B 1 tablet p.o. twice daily
Chloroquine 500 mg p.o. every Monday

April 21

- Intravenous Crystapen was discontinued and Ombu was given 900,000 units of Procaine Penicillin intramuscularly for five days. Intravenous Chloramphenical was changed to oral Chloramphenical 500 mg q 6h for five days.
- When the intravenous was discontinued, Ombu took care of her child.
- Ombu developed a wound infection which was cleansed daily and covered with a dry dressing.

May 20

- Ombu and her baby went home from Madang General Hospital. She appeared to be in good spirits and quite unconcerned about her unusual experience. She seemed to accept the birth of her stillborn child and the birth of her son by cesarean section a week later as something quite normal, something that could happen to anyone, anywhere, at anytime.

The Infant

The infant cried within a few seconds of delivery and was pink in color. He weighed 1,910 gm. The following medications were prescribed and given:

- Vitamin K (Konakion) 1 mg intramuscularly. This medication is given immediately after birth as a prophylaxis against coagulation defects related to Vitamin K deficiency.
- Crystalline Penicillin 125,000 units IM BID x 7 days
- Streptomycin 50 mg IM daily x 7 days
- Antibiotic eye ointment daily x 5 days

The baby was fed with expressed breast milk every three hours, so that he wouldn't tire sucking at his mother's breast. When he grew stronger he breastfed each day, gradually increasing the number of times. Tube feedings were slowly decreased in number until he was able to be breastfed all the time.

On April 23, the child became quite jaundiced, and his total bilirubin showed 13.2 mg/100 ml. He was placed under the photo-light four times a day for one to two hours at a time. Subsequently, his total bilirubin results were: April 26 — 16 mg/100 ml; April 29 — 14.4 mg/100 ml; May 5 — 12.8 mg/100 ml.

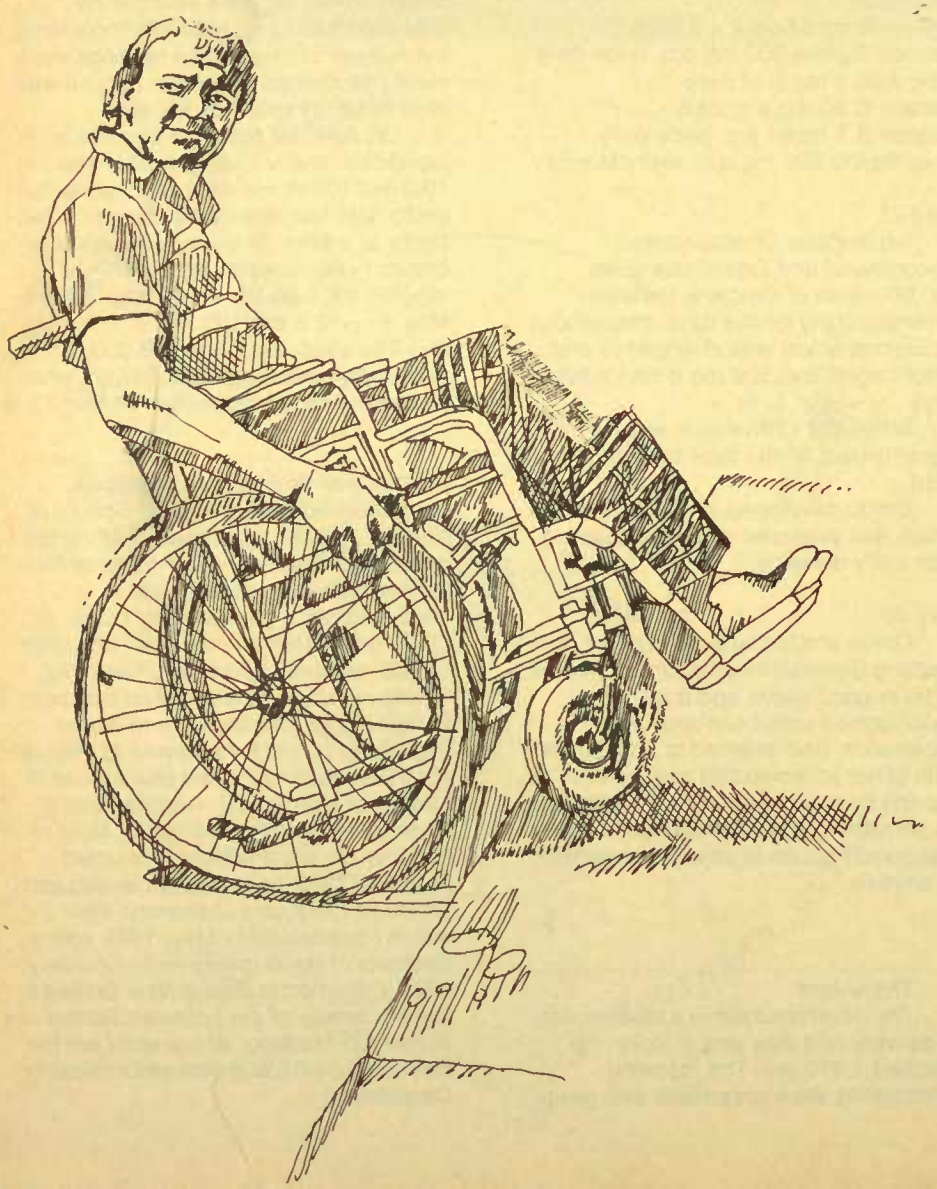
The child was given a B.C.G. vaccination. He weighed 2,200 gm when he went home with his mother on May 20.

Dolores Hall of Erickson, Manitoba, graduated from St. Boniface School of Nursing in 1963. "I worked in Manitoba and Alberta before coming to Papua New Guinea with Lutheran Mission in 1966-1970 as a general duty nurse. In 1971 I graduated from Frontier Graduate School of Nurse Midwifery, Kentucky, having completed the required course in Family Nurse Practitioner and Nurse Midwifery. In 1971, I returned to Papua New Guinea, and for two years I was in charge of a large T.B. hospital with a large general outpatient clinic. Most of the time we were without a resident doctor. In 1973, I returned to Canada and attended Dalhousie University, from which I graduated in May, 1975 with a Bachelor of Nursing degree. In February, 1976, I returned to Papua New Guinea to join the faculty of the Lutheran School of Nursing in Madang. At present I am the instructor, both classroom and clinical for Obstetrics."

TOWARDS INDEPENDENCE FOR PARAPLEGICS

Ane Marie Hansen

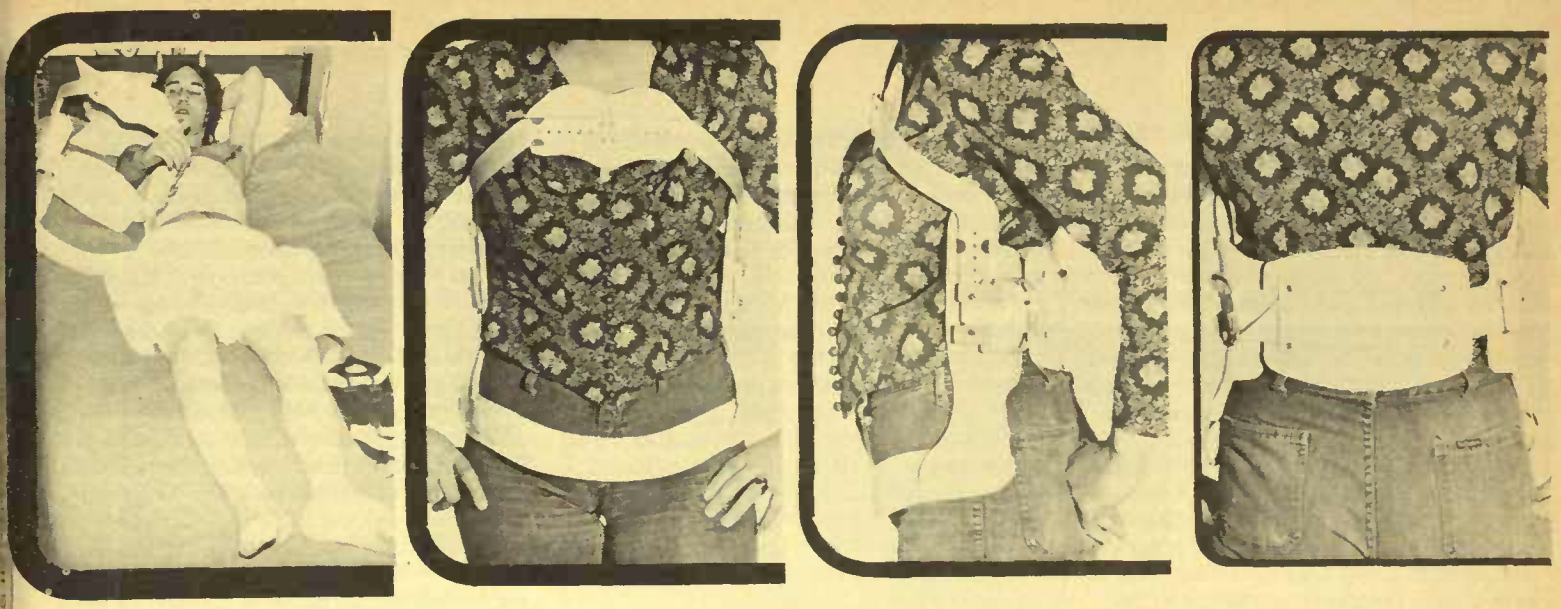
Remarkable gains in the quality of life of paraplegics result from achieving successful rehabilitation, from living at home and from a productive occupation. Meeting these challenges is well worth the time and effort of everyone involved.



Good rehabilitation is a complex and difficult process that requires constant evaluation. It can make the difference between the successful or unsuccessful return of the paraplegic to a full and active life. The goal of rehabilitation is to restore in the paraplegic a sense of confidence in his own abilities so that he can achieve a level of self care and independence. Withdrawal, denial and anger can be an expression of fear of facing reality. To overcome this fear and to come to accept the reality of his disability and his physical limitations, the paraplegic needs support from the health team and from his family. His capabilities must be emphasized, encouraged and developed if he is to gain a maximum level of personal independence. These goals can be achieved with help from a team of many skilled people — physicians, nurses, physiotherapists, occupational therapists, social workers and vocational counselors — who should be flexible and focus on the individual by assessing and responding to his needs.

Rehabilitation starts the minute the patient sustains an injury. In spinal cord injury patients who are usually immobilized for a period of time, initial rehabilitation is based on the prevention of complications such as decubitus ulcers, urinary tract infections, bowel impaction, thrombophlebitis, muscle contractures and mental depression. At this early stage, the physical management of the patient is primarily the responsibility of the nurse and therapists. Once the patient becomes increasingly mobile, the role of the nurse takes on new dimensions. The caretaker role decreases and she now assumes the role of teacher, counselor and facilitator.

One of the most challenging responsibilities for the nurse lies in her ability to teach the patient self-care, which includes the prevention of complications. He needs to know the signs and symptoms of impending problems, to be alert for them, and to take



Once the spinal cord injured patient is allowed up in the chair, he is elevated gradually usually wearing a brace such as this Jewitt Hypertension brace. Tensor bandages or anti-emboli stockings and an abdominal binder are also used to alleviate the problems of orthostatic hypotension.

Historical Perspective

The earliest recorded reference to injury of the spinal cord resulting in paraplegia can be found in the Edwin Smith Papyrus in the possession of the New York Historical Society.

Written some 3,000 years ago, the author suggested that no treatment should be undertaken.[1]

This approach towards paraplegia, and subsequent gloomy prognosis, continued throughout the centuries, up to the second world war. Mortality rate was high. Statistics for World War One show, that over 80% of the paraplegics died within the first few months following injury.[2]

The need for better treatment methods was recognized by a neurosurgeon, Sir Ludwig Guttman. In 1944, the National Spinal Injuries Centre was opened in Stoke Mandeville Hospital, England, under his leadership.[3] Similar centers are now found all over the world. With the advanced understanding and treatment of paraplegia and the introduction of antibiotics, the mortality rate over a period of more than 20 years has been reduced to just under 18%.[4]

basic measures to prevent their progression. If the patient can achieve preventive self-care, then the rehabilitation process can be considered a success.

In teaching fundamental care to the patient, the nurse must consider the many factors which will influence his behavior and learning. Such factors include: the level of disability, the patient's potentials, motivation, intelligence, cultural background, social status, emotional status, changed body image, response of family and friends to his disability and perhaps most important, his own perception of how his disability is going to govern his future. The nurse should teach with a realistic approach. Successful rehabilitation will not be achieved by denying the existence of a disability or by minimizing the hard work needed to achieve a level of independence. One of the best ways for the patient to learn is to have him actively participate with the team in his plan of care. Involvement and accomplishment are the key factors in stimulating and maintaining the patient's interest and in motivating him to achieve self management. A program emphasizing self care is now in operation in the Rehabilitation Unit, St. Michael's Hospital, Toronto. Nursing care and teaching cover a number of areas.

Aspects of Self-Care

One of the most important aspects of rehabilitating the paraplegic patient lies in teaching bowel and bladder management. The loss of voluntary control of these functions often produces in the patient a feeling of shame, which later may present itself in the form of anger, frustration and hostility. The nurse should listen with sensitivity to spoken and unspoken cues and should encourage him to accept what he cannot alter. At the same time she can stress that with persistence, interest and careful management, he will be virtually "accident free." Achieving control not only is important to his self-esteem, but is crucial to his future vocational re-establishment, as well as to his social integration and participation in various activities.



Bowel

A history of his previous bowel habits is taken, and a regime of emptying the bowel every forty-eight hours is commenced. Anticipating that the patient will get back to work or school, the most convenient time to establish a routine is immediately after supper. This also leaves the evening free for social or recreational activities. Explanations are given to the patient about the physiolgical functions of the bowel and about how paralysis has affected the voluntary control of this mechanism. Initially, the routine consists of having the patient take either 30 cc of Aromatic Cascara, 3 Cascara Sagrada 300 mg pills or 15 cc Cascara and 15 cc of Milk of Magnesia every other morning after breakfast. This is followed by a Dulcolax suppository in the evening, usually inserted just before supper to take advantage of the gastrocolic reflex. Once the patient is allowed up, he is taken to the bathroom on a commode chair. As his balance and transfers improve, he can transfer directly to the toilet for evacuation. Digital stimulation is essential especially at the beginning of the regime. Reasons are explained to the patient, since it is often difficult for him to accept this. It is important that he check the color, amount and consistency of the stool since he may have to alter his laxatives accordingly, may need a second suppository or perhaps a stool softener. With proper and consistent management, enemas are usually not necessary, and are given only as ordered by the doctor. As a regular routine is established, the laxative is gradually decreased, and a natural laxative such as prune juice may be substituted; a glycerine suppository is used instead of the Dulcolax suppository and finally, a well-lubricated gloved finger for digital stimulation may be sufficient for bowel evacuation.

Dietary instruction is also important to inform the patient of the various foods that act as a laxative, provide bulk or cause constipation. A well-balanced diet with sufficient bulk is advised. The patient soon gets to know what he can or cannot tolerate. He is made alert to the possible development of hemorrhoids due to continuous constipation, and to the symptoms of impaction — i.e. frequent passage of liquid stool, not to be confused with diarrhea. He is told to watch for symptoms such as abdominal distension, slight difficulties in respirations (increasing intra-abdominal pressure interferes with the expansion of the diaphragm), increasing spasticity, headache and general malaise.

Bladder

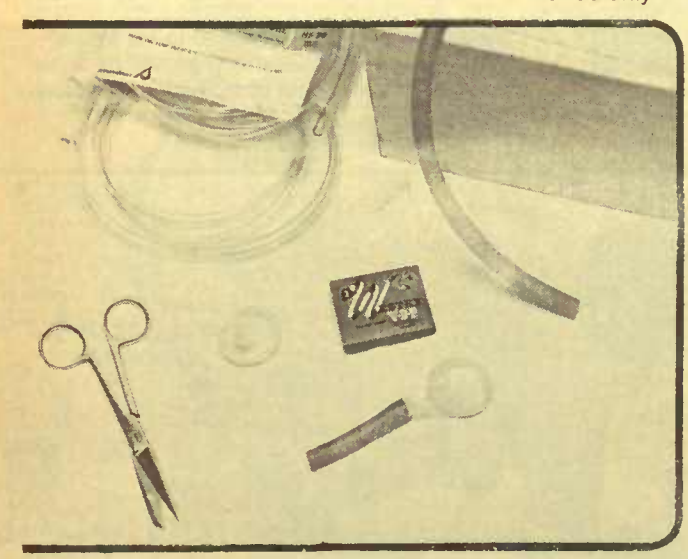
Management of the neurogenic bladder varies from center to center. I shall attempt here only to discuss the management as it is carried out in the Rehabilitation Unit of St. Michael's Hospital.

Insertion of an indwelling catheter, Foley or Gibbons, is initiated upon the patient's admission to hospital. Since an indwelling catheter is a constant contributing factor to urinary tract infection, the sooner it can be removed and the patient placed on intermittent catheterization, the lesser the chances of infection. A large intake of fluid (3,000 cc in 24 hours) reduces the chances of infection, as well as decreasing the incidence of renal and bladder calculi. Cranberry juice can be given to help acidify urine, (therefore decreasing the odor), but usually Ascorbic Acid 500 mg qid is given for this purpose. Urinary antiseptics are given only if indicated. With decreased muscle activity and decalcification taking place, the intake of milk is restricted for use in tea and coffee only. This helps prevent formation of renal calculi and deposits of calcium in muscles, joints or soft tissue. Adherence to a strict "controlled intake" routine is well established before an intermittent catheterization program is started.

All patients with a neurogenic bladder are placed on intermittent catheterization as soon as possible. An Intravenous Pyelogram (IVP) is done to evaluate kidney function and to ensure that no reflux is present. A cystometrogram is not routinely done. When an estimated bladder volume of approximately 500 cc has been reached, the patient initiates voiding. Specific times for voiding vary greatly with each individual and an appropriate regime is reached only by trial and error. Usually, patients try to empty the bladder before or after each meal and at bedtime. Certain patients who have a low output during the day, may have diuresis during late evening and night, and subsequently will have to be catheterized at 2 a.m. or 6 a.m. as indicated.

Controlled Intake

Time	Amount
0800	600 cc - Breakfast
1000	400 cc - Midmorning
1200	600 cc - Lunch
1500	400 cc - Midafternoon
1700	600 cc - Supper
Day intake	2600 cc
1800 - 2400	200 cc
0600	200 cc
Night intake	400 cc
24 hour total intake	3000 cc

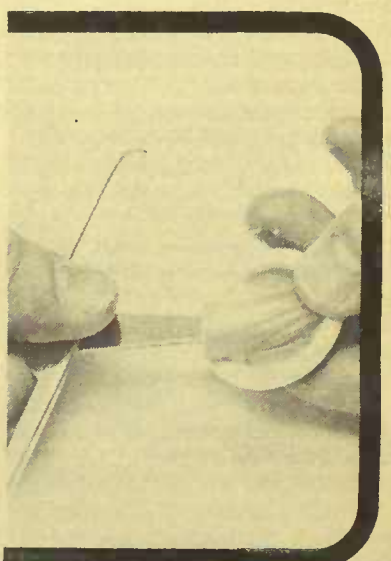


To make an economical "Texas type" condom for a urinary drainage system:

1) cut a 2-inch piece of rubber tubing and a 1/4 inch piece of enema tubing.



2) place condom over the rubber tubing with condom rolled inside. Insert enema tubing inside the rubber tubing forcing the condom down until the edges are even.



3) make a cut in the condom large enough for urinary flow.

Due to the disruption of the normal physiological function of the bladder, the voiding reflex center in the spinal cord is explained in detail to the patient. It is important that he is aware of the goal of the bladder regime since his cooperation is essential to its success. The dangers of overdistending the bladder by exceeding his intake during the evening or night (without the knowledge of the nursing staff) is stressed. He is expected to keep a close eye on signs of bladder fullness. If his lesion is at or above T6, he may suffer from autonomic dysreflexia, which presents itself in the form of throbbing headache, dilated pupils, perspiration above the level of the lesion, high blood pressure, low pulse, stuffy nose and increased spasm. Convulsions and intracranial hemorrhage may occur if action is not taken to empty the bladder.

Ways to initiate the voiding reflex vary from patient to patient. Tapping of the lower abdomen just above the symphysis pubis, stroking the inside of the thighs or genitalia may trigger this response. In lower motor neuron lesions, Credé method* may be used; or creating intra-abdominal pressure by pushing as if to have a bowel movement may be the only way to stimulate the voiding reflex. Most effective of all is rectal stimulation, as the pudendal nerve innervates both the external urinary and rectal sphincter. However, this method is rarely used, as it tends to interfere with the bowel routine.

After approximately fifteen minutes of stimulation and after the patient has voided, if possible, a sterile catheter is inserted under strict aseptic technique to obtain the residual urine. The bladder is then irrigated with 1/4% Acetic Acid until returns are clear. The bladder volume is calculated by adding the amount voided with stimulation, plus residual urine. A note is also made of how much, if any, urine was collected in the leg bag since the last catheterization. This regime is continued until the residual urine is well under 100 cc which may take many weeks. In fact, it may never be successful without surgical intervention.

* Pressure applied above symphysis pubis to empty bladder.



4) attach condom to a straight plastic connector, then to rubber tubing, then to a leg bag.

If no response is seen after several weeks, a radiological examination by Dynamic Voiding Cystourethrogram is performed to determine the level and cause of dysfunction. It may be due to spasm of the external sphincter, urethral strictures, bladder calculi or reflux. A cystoscopy is generally performed to rule out prostatic enlargement, lithiasis, and if present, these are surgically treated.

To improve the reflex contractions of the detrusor muscle, a course of Urecholine 15 to 30 mg may be given 45 minutes prior to voiding. In other cases, Probanthine may be used in an attempt to reduce excessive bladder contractions. After many weeks, sometimes months, on intermittent catheterization, the patient may need an external sphincterotomy in order to weaken the sphincter muscle to facilitate voiding. After a period of ten days to two weeks following the sphincterotomy, the indwelling catheter is removed and intermittent catheterization is started again, until the residual urine is substantially under 100 cc. The sphincterotomy may have to be repeated and partial resection of the bladder neck may be necessary. Condom drainage is needed for most patients.

Once a reflex micturition with low residual urine has been established, the strict controlled intake is relaxed, but the patient is instructed to continue with a minimum intake of 3,000 cc per 24 hours and to empty his bladder four or five times a day as indicated and according to intake.

Self-catheterization

To carry out such a bladder program for many patients at the same time is very time consuming for the nursing staff. Partly for this reason, but moreso to adhere to the total self-care concept of this unit, we have recently begun to teach patients how to perform their own intermittent catheterizations and have found it to be most successful. Not only did the patients show an enthusiastic response to this, but it has enabled the nursing staff to start patients much sooner on such a program. Needless to say, not all paraplegic patients are candidates for self-catheterization. Careful selection of patients, instruction and close supervision of their technique is required. Occasional "spot checks" are needed to ensure that they are maintaining good sterile technique. No increase in urinary tract infection has been noticed in patients performing self-catheterizations in our rehabilitation unit.



Self-medication

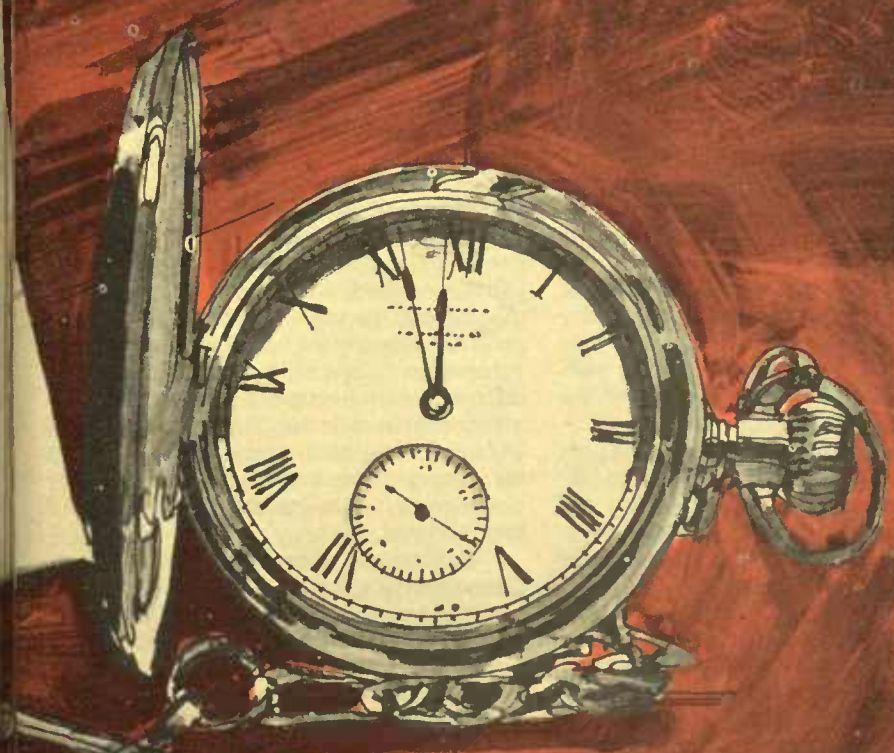
The total self-care concept is also extended to include medication, except for PRN medicines. The patient is issued a weekly supply of medication; he is taught the actions and side effects of the drugs and is instructed when to take them. He is responsible for keeping a record of his medication on a special sheet. A weekly assessment by the nurse is done with reissuing of medication to see how he is managing.

Skin Care

One of the most dangerous problems of paraplegia lies in the lack of sensation below the level of the lesion. Since uncomfortable stimuli are not felt, the automatic response to move, or investigate the cause of the discomfort is not present. Consequently, the paraplegic must be on the lookout for complications, especially decubitus ulcers.

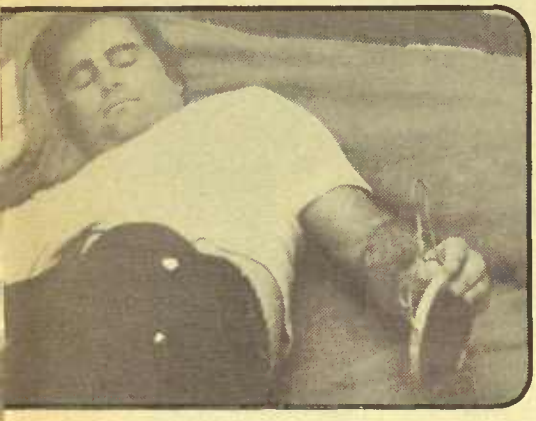

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He is informed that prolonged pressure diminishes the blood supply, and thus the nutrition to the underlying cells. This, in turn, may lead to necrosis and ulceration. The areas he should observe are those over the sacrum, coccyx, trochanters, ischial tuberosities, and the heels and knees. If a pressure sore does occur, great care should be taken to prevent infection, a development which could lead to osteomyelitis and gram-negative septicemia.



Pressure sores are completely preventable. When the patient is in bed, it is absolutely essential that he is turned and properly positioned every 2-3 hours. If the patient sleeps on his abdomen, however, he can stay four hours or more in one position. When up in the wheelchair, he must lift himself up or shift position to relieve the pressure a few times each hour. It must become a new and relearned habit, since it is the only means by which pressure sores are prevented. He is taught to inspect his skin every night for redness, blisters or bruises or to look for a rash. A hand mirror is used for the inspection of the sacrum and buttocks. "The rear view mirror check." He is instructed to massage the skin well with cocoa butter or lotion. Alcohol should be avoided as it tends to only dry the skin. He should be careful not to drop or scratch his legs during transfers, not to burn himself on the water pipe at a sink, to watch that hot water is not dripping on his feet while relaxing in a bath. The list goes on and on...

Thrombophlebitis

Another potentially dangerous problem the patient should recognize is the possibility of the development of thrombophlebitis, which could easily go undetected because of his lack of sensation. He must check for unusual swelling especially in the loose connective tissue of the popliteal space, ankle or suprapubic area as well as checking for unusual warmth or redness of an area.

Contractures

The prevention of foot drop and hip and knee flexion contractures is initially the responsibility of the nurse. Proper positioning and body alignment as well as range of motion of all joints is carried out until the patient is able to do this for himself.

Spasm

A condition most paraplegics experience is that of involuntary muscle spasms. If the patient can learn to utilize the spasms to his advantage, eg. to help support the trunk, during turning or transfer or even if the patient is able to walk with long leg braces, spasms can be of positive value. Unfortunately, muscle spasms usually present a great problem to the patient since they can be severe and occasionally painful. They can throw him off balance in the wheelchair, complicate dressing, and present other problems, since they are apt to occur at any time, any place, with occasional embarrassment to the patient. Muscle spasms, however, can also act as warning signals of impending problems if there is suddenly a change in their frequency and severity. They alert the patient to be watchful for signs of bowel impaction, urinary tract infection, epididymitis, renal and bladder stones, appendicitis, thrombophlebitis or other complications.

Until now, anti-spasmodic drug therapy has proven to be of relatively little value in the control of muscle spasms. In severe cases it may be necessary to inject alcohol into the spinal canal. Other surgical means such as longitudinal lateral myelotomy, interrupting the reflex arc, or anterior spinal root rhizotomy are only done as a last resort.[5]

Pain

In spite of the fact that the paraplegic patient has lost sensation below the level of the lesion, frequent occurrence of pain in the anesthetized area of the body is experienced by many patients. The pain is often aggravated by such conditions as bladder infection, or the presence of calculi, pressure sores, constipation, other underlying physiological causes, or by depression. Most patients, however, are able to endure the pain; others may require a mild analgesic, and only in very severe cases where the pain interferes greatly with the patient's rehabilitation and vocational re-establishment is surgical intervention required.[6] Relief of chronic pain has occasionally been successful through the use of dorsal column stimulators.[7]

One of the best ways to alleviate the pain is to have the patient engage actively in his rehabilitation program. In understanding and meeting both his physical and emotional needs, most patients learn to accept and live with their pain.

Sex-related Problems

One major concern of the paraplegic patient is to what extent his injury will affect his sexual function. For male paraplegics, physical sexual potential is related specifically to the level and extent of the lesion. Most men with an upper motor neuron lesion experience reflex erections, but these may be of too short a duration to allow for coitus. In patients with complete lower motor neuron lesions, 75% are unable to obtain an erection, 25% may experience psychogenic erections produced by mental and physical stimuli, but few are able to complete intercourse. For incomplete lesions, the percentage of successful coitus increases.

Female paraplegics have the potential to resume sexual activity and to become pregnant, although the ability to experience orgasm is usually lost.[8]

The loss of sexual prowess may be a great blow to the male's ego. In the past, much emphasis has been placed on "performance" rather than on the psychological factors involved in satisfying a mate in sexual relations. Counseling that emphasizes these psychological factors and openly discusses alternative ways of achieving sexual satisfaction for both partners will be valuable in helping them adapt to the changes. By stressing the worth of the person as an individual and by helping them to understand their problems and limitations, sexual adjustment is possible.

Vocational Re-establishment

Helping the patient to recover his earning power is an important aspect of his return to the community and meets a strong psychological as well as practical need. Work gives a person the opportunity to find his own identity and gives him the feeling of being useful. With an increasing number of accidents each year, more people become paraplegics. With increased life expectancy, it is of utmost importance financially, as well as for their own sense of accomplishment, that paraplegics eventually be gainfully employed.

Plans for future vocational re-establishment are discussed with the physiatrist and social worker. The social worker, establishes contact and registers the patient with Vocational Rehabilitation Services. A psychological assessment of intellectual functioning, aptitude and interest is usually required. A vocational counselor will then assess the patient's motivation and potential capacity for future vocational achievements, and will follow the patient after discharge from hospital. Necessary home alterations, ie. widening of doorways, building of ramps, installation of hand controls in the car, arrangements for transportation to school or university, on-the-job training, are all part of their services.

Patients are encouraged to join the Canadian Paraplegic Association, which provides valuable information and assistance to them and their families.

Sports and Recreation

The independence learned through rehabilitation and the use of new, more easily maneuvered equipment such as collapsible lightweight wheelchairs and hand-controlled cars, has liberated the paraplegic from the



dependency role. He can extend his vocational, social and recreational activities into fields previously considered out of bounds. Sports and recreation play an important role in the social integration of the disabled back into the community bringing to the person a sense of belonging and self-fulfilment. With prior planning, paraplegics can now travel extensively and can participate in sports activities such as basketball, weight lifting, bowling, archery, rifleshooting, fishing and hunting, boating and swimming, dart and ping-pong contests and others.

Summary

Good rehabilitation emphasizes the abilities rather than the disabilities of the paraplegic and promotes the greatest level of self-care and independence possible. However, even with a level of independence, there still exist societal barriers that prevent the disabled from assuming a greater involvement in the community.

Educating the government and the public, about the need for more and better suitable housing, more vocational opportunities, fewer physical barriers such as high curbs, stairs and narrow doorways that prevent access to pub. and commercial buildings and trying to encourage positive attitudes toward the disabled will help bring the paraplegic out of isolation and allow him to develop a full, active life.

Ane Marie Hansen (S.R.N., New End Hospital, England) is head nurse of the Rehabilitation Unit, St. Michael's Hospital, Toronto. She prepared this article while taking a course in "Advanced Rehabilitation" given by George Brown College, Toronto. She states "I would like to acknowledge my gratitude to Mrs. Hazel White for the directions in writing this article and to Dr. J.M. Houston for many years of guidance in working with spinal injured patients".

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Clinical Wordsearch
Answers

Puzzle # 3 (appears on page 42)

1	Asthma	24	Rales
2	Pneumothorax	25	Crepitus
3	Pulmonary Function	26	Pleurisy
4	Respirations	27	Pleural Rub
5	Blood Gas	28	Cough
6	Tidal	29	Smoke
7	Lung	30	Cancer
8	Alveoli	31	Apnea
9	Medulla	32	Sputum
10	Bronchogenic	33	Dyspnea
11	Tumor	34	Atelectasis
12	Neoplasm	35	Influenza
13	Clubbing	36	Postural Drainage
14	Cheyne-Stokes	37	Humidifier
15	Oxygen	38	Haemoptysis
16	Breathing	39	Mucus
17	Embolus	40	Oral
18	Ribs	41	Nasal
19	Cystic Fibrosis	42	Nares
20	Bronchus	43	Air
21	Tracheitis	44	Pain
22	C.O.L.D.	45	Prn
23	C.H.F.	46	Q.S.

Hidden Answer: No smoking; lungs at work.

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The pandemic influenza of 1918

Gladys Morton

An elusive virus is claiming appreciable newspaper space these days, stirring up a good deal of controversy. The well-publicized threat of 'Swine Flu' has launched plans for mass immunization against the virus and brought sceptical sneers from those who term it a 'phantom' epidemic. But the death of the young man in Fort Dix, New Jersey, early this year was attributed to Swine Flu, reputedly a descendant of Spanish Influenza, a flu virus with the distinction of causing the greatest epidemic of flu in modern history. The following is a reprint of an article about that epidemic printed in The Canadian Nurse *in December, 1973.*

Photo courtesy Public Archives Canada

On November 11, 1918, the First World War came to an end. While millions danced in the streets, millions more were dying of Spanish influenza. It was to be the most destructive pandemic ever known on this planet. The London Times of that day reported: "Never since the Black Death has such a plague swept over the face of the world. Never perhaps has such a plague been so stoically accepted."

Sir McFarlane Burnet, an Australian virologist who is possibly the most eminent authority alive, estimates that between 25 and 50 million died of Spanish influenza, most in the brief period between the beginning of October and the end of December 1918.[1] Beside it the Black Death pales, with 25 million dead over a period of two years, 1348-50.

The *Encyclopedia Britannica* reports: "In the autumn of 1918 much of the northern hemisphere was blanketed in influenza in approximately one month." In fact, few places on the globe escaped; St. Helena and New Guinea were among them.[2]

Symptoms

The incubation period and onset of the disease were so short that apparently healthy people were suddenly overcome, and within an hour could become helpless with fever, delirium, and chills. Severe headache, pains of varying intensity in muscles and joints, acute coryza, inflammation of the upper respiratory tract, accompanied by temperatures of 101° to 105°, were common but not unusual for influenza.[3] What was unique, however, was the often fatal viral pneumonia that quickly followed even slight exertion. It could occur at any time during the illness — a patient could be convalescing one day and dead the next.

During an interview with Dr. Charles Mitchell, honorary professor, Department of Microbiology and Immunology, University of Ottawa, I asked about this phenomenon: "Was there an explanation for the pneumonia? Did the virus behave differently than in other pandemics?"

"Yes," he said, "in the majority of specimens of Spanish influenza that I examined, the virus had attacked the parenchyma of the lung. Normally, Type A influenza virus infects the mucous surface of the lung, but in 1918 it entered the organ itself. This was undoubtedly the cause of the swift, often fatal, pneumonia that frequently followed exertion."

He continued," I was a young pathologist stationed at Lethbridge, Alberta, when flu broke out, and was soon up to my elbows in influenza specimens. One day the porter brought me a kidney and a piece of lung. I asked him if the patient had died recently."

"Yes," he said, "just this morning."

"Do you know his name?" He did.

"My God," I said,"that's my insurance agent. I called him two days ago and I have an appointment with him tomorrow." The man had been sick less than a day.

Wiser than most to the tragedy of exertion, Dr. Mitchell and his wife took precautions against coming down with flu by stocking the shelves with fluids, placing their beds in front of the fire, and arranging that the caretaker look in on them should the inevitable day arrive, which it did. And throughout their illness,

→

Influenza Bulletin

The following are recommendations from an Influenza Bulletin which was published in *The Canadian Nurse* in January of 1919. The bulletin appeared as a result of a meeting of the Public Health Association in Chicago, Illinois, December 9-12, 1918. In its entirety, the bulletin dealt with the etiology of influenza, suggestions for organized prevention measures and public education, the use of volunteer help, social and relief measures, provision for fatalities, and interestingly — the pros and cons of preventive vaccines. The few recommendations presented here are concerned with prevention of the disease, and indicate some practical concerns posed by the epidemic.

"The preventive measures recommended by the committee are as follows:
A. Efficient organization to meet the emergency, providing for a centralized coordination and control of all resources.
B. Machinery for ascertaining all facts regarding the epidemic:
1. Compulsory reporting.
2. A lay or professional canvass for cases, etc.
C. Widespread publicity and education with respect to respiratory hygiene, covering such facts as the dangers from coughing, sneezing, spitting; and the careless disposal of nasal discharges; the advisability of keeping the fingers and foreign bodies out of the mouth and nose; the necessity of hand washing before eating, the dangers from exchanging handkerchiefs; and the advantages of fresh air and general hygiene. Warnings should be given regarding the danger of the common cold, and possibly colds should be made reportable so as to permit the sending of follow-up literature to persons suffering from them....
D. Administrative procedures:
1. There should be laws against the use of common cups, and improperly washed glasses at soda fountains and other public drinking places, which laws should be enforced.
2. There should be proper ventilation laws, which laws should be enforced.
3. Closing — Since the spread of influenza is recognized as due to the transmission of mouth and nasal discharges from persons infected with influenza .... gatherings of all kinds must be looked upon as potential agencies for the transmission of the diseases.... Non-essential gatherings should be prohibited. Necessary gatherings should be held under such conditions as will insure the greatest possible amount of floor space to each individual present, and a maximum of fresh air, and precautions should be taken to prevent unguarded sneezing, coughing, cheering etc.

Where the necessary activities of the population, such as the performance of daily work and of earning a living, compel considerable crowding and contact, little is gained by closing certain types of meeting places. If .... the community can function without much contact between individual members thereof, relatively much is gained by closing or preventing assemblages.

Schools — As to the closing of schools, there are many questions to be considered:

- Theoretically, schools increase the number and degree of contacts between children. If the schools are closed, many of the contacts which the children make are likely to be out of doors. Whether or not closing will increase or decrease contacts must be determined locally. Obviously, rural and and urban conditions differ radically in this regard.
- Are the children, in coming to and going from school, exposed to inclement weather or long rides in overcrowded cars?
- Is there an adequate nursing and inspection system in the schools?
- Is it likely that teachers, physicians, and nurses can really identify and segregate the infected school child before he has an opportunity to make a number of contacts in halls, yards, rooms, etc.? We suggest that children suspected of having influenza, and held in school buildings for inspection, should be provided with and required to wear face masks.
- Will the closing of schools release personnel or facilities to aid in fighting the epidemic?
- If schools are kept open, will the absence of many teachers lower the educational standards?
- If a number of pupils stay at home because of illness or fear, will they not constitute a heavy drag upon their classes when they return?
- If schools are closed, is there likely to be an outbreak in any case when they are reopened?

Churches — If churches are to remain open, services should be reduced to the lowest number consistent with the adequate discharge of necessary religious offices, and such services as are held should be conducted in such a way as to reduce to a minimum intimacy and frequency of personal contact.

Theatres — As regards theatres, movies, and meetings for amusement in general, it seems unwise to rely solely or in great part upon the ejection of careless coughers. In the first place, it is difficult to determine who is a careless cougher, and after each cough, danger has already resulted .... Discrimination as to closing among theatres, movies etc. on the basis of efficiency of ventilation and general sanitation, may be feasible.

Saloons, etc. — The closing of saloons and other drinking places should be decided upon the basis of the probability of spread of the disease through drinking utensils and the conditions of crowding.

Dance Halls, etc. — The closing of dance halls, bowling rooms, billiard parlours and slot-machine parlours, etc. should be made effective in all cases where their operation causes considerable personal contact and crowding.

Street Cars, etc. — Ventilation and cleanliness should be insisted upon in all transportation facilities. Overcrowding should be discouraged. A staggering of opening and closing hours in stores and factories to prevent overcrowding of transportation facilities may be cautiously experimented with. In small communities, where it is feasible for persons to walk to their work, it is better to discontinue the service of local transportation facilities.

Funerals — Public funerals and accessory funeral functions should be prohibited, being unnecessary assemblies in limited quarters, increasing contacts and possible sources of infection.
4. Masks — The wearing of proper masks in a proper manner should be made compulsory in hospitals and for all who are directly exposed to infection. It should be made compulsory for barbers, dentists, etc. ... Persons who desire to wear masks in their own interests, should be instructed as to how to make and wear proper masks....
5. Isolation — The isolation of patients suffering from influenza should be practiced. In cases of unreasonable carelessness, it should be legally enforced most rigidly.
6. Placarding — In cases of unreasonable carelessness and disregard of the public interests, placarding should be enforced.
7. Coughing and sneezing — Laws regarding coughing and sneezing seem to be desirable for educational and practical results.
8...

1918...

neither budged from the bed until their temperatures were again normal.

Not so wise was my own uncle, Russell Main of Pincher Creek, Alberta. While convalescing from flu in hospital, he hopped out of bed to assist a nurse with a delirious patient and died 48 hours later of pneumonia. His two brothers arrived home from overseas to face, not the warm welcome they expected but the shock of a sudden tragedy.

Age of incidence

Although influenza has occurred in epidemics since recorded time, easily diagnosed by its symptoms, it has traditionally been considered a minor,even humorous ailment. In the seventeenth century it was known as "the jolly rant," "the new delight," and "the gentle correction."[4] But, for the very young and the very old who have always provided the mortality statistics, it was a wry form of humor. In the 1918 pandemic, a curious reversal occurred and the "joke" was on the healthy young adults, those between the ages of 20 and 40, who provided 60 percent of the deaths.[5] This phenomenon was unique to Spanish influenza and has never been explained.

Where it began

No one knows where the disease started. In his book *I Remember Him*, Hans Zissner suggests that it began over the course of several years from a large number of points of origin.[6] Or, it may have started in an overcrowded army camp in Kansas, March 11, 1918. On that day, 107 patients were admitted to hospital suffering from a sudden acute form of flu that quickly enveloped the 26,000 personnel, many of whom were destined for the war of France.[7]

But, for those over 60 who remembered the event, the harbingers of Spanish influenza were the cold, exhausted troops in the filthy trenches of France.

Whatever its origin, the pandemic did not begin in Spain. However, since the King of Spain was one of the early victims, his country, by implication, was saddled with the responsibility and the name.[8]

Canada

With a population of eight million, Canada lost 30,000, including 108 doctors from Ontario and the prairie provinces alone. Deaths in Ontario had reached 5,000 by November.[9]

The musty pages of *The Ottawa Journal* of October 1918 report: "Street cars rattle down Bank Street with windows wide open and plenty of room inside. Stores open at 10 a.m. and close at 4 p.m. Civil servants are let off at 3 p.m. for last-minute shopping. Schools, vaudeville theatres, movie palaces are dark; pool halls and bowling alleys, deserted."

One eager group confronted the mayor with a request that liquor prohibition be eased for those who needed a little "nip" to calm the nerves. But the only strong thing in Ottawa was the formaldehyde used to disinfect the street cars. A black-edged notice from the Bell Telephone Company urged its customers to make emergency calls only, since most of their staff were sick. A front page plea for nurses and women to make pneumonia jackets and masks fought for attention with the exuberant news of the last days of the war.

United States

Influenza was first reported in America August 28, at a naval hospital in Chelsea, Massachusetts.[10] It spread rapidly over the entire United States attacking possibly 20 million[11] and killing 548,000. Life insurance claims from October 1 to December 24 were $52 million.

Although virulence was constant across the nation, it varied widely in local areas, with adjacent communities reporting enormous differences in death rates. Curiously, a change in the weather at the time of onset affected mortality in eastern American cities. When the temperature and humidity rose, the death rate rose, and when they fell the death rate also fell; no change in weather caused no change in mortality.[12] Philadelphia had the highest mortality in the east, with 650 dying in a single day, and an overall rate of 210 per 100,000, as compared to Milwaukee, with 21 per 100,000.[13]

Schools, churches, and theaters were closed. There was public concern about isolation techniques in hotels where sick and dead were removed from rooms that were then cleaned with general mops and dusters.

Teachers became nurses, and doctors were run off their feet and into their graves. In parts of Wisconsin, every doctor was sick. Police and social workers found entire families helpless, children neglected, and the dead unattended. In some cases, whole families were found dead. For want of care, healthy children were taken to hospital with their sick and dying parents. A New York City doctor made 50 calls in one city block in a day and had to refuse more.

The only protection advised, or indeed known, by the medical authorities — isolation and face masks (improvised by stretching three layers of butter muslin over a tea strainer) — was, according to one doctor, as much use as a diver's suit and handcuffs.[14]

My search for material in the medical journals of the day was hampered by the absence of volumes for 1918 and 1919. However, the *American Journal of Public Health* is extant and helped fill the gap with such reports as this:

"The epidemic is known to have caused so many fatalities within a few days, that it is safe to say that morbidity preceded mortality by a few days at most."[15]

And then this surprising observation: "The cause of the lower incidence of flu among colored people during the epidemic may have been due to the prevalence of tuberculosis among negroes. There seems to be some unexplained resistance to flu among tubercular patients."[16]

As for those unfortunate enough to be pregnant during those few months, the *American Journal of Medical Sciences* reports: In a study of 1350 cases of pregnant patients with influenza, almost half developed pneumonia and of these 50 percent died.[17]

The *American Journal of Public Health* also reported that mortality aboard troop ships was twice that on land. Possible reasons for this were: the food was poor; the men ate little and then washed their mess kits in a communal tub of tepid water, using their hands to wipe off the food, they slept badly on unfamiliar hammocks in brightly lit holds; and, for their two compulsory showers during the crossing, the men were lined up naked on deck to await a sloshing of icy sea water. Needless to say, when this report was made public, future troops fared considerably better.[18]

For those who were sick at disembarkation, mortality was in direct ratio to the distance from the nearest hospital.[19]

Europe

The disease spread just as quickly in Europe, with a death rate to match. Every member of the tiny Swiss army had to take to his bed. American doctors in France treated 70,000 of their own troops, with 32 percent mortality. England suffered 150,000 dead in November and



1918...

December. Half the population of Manchester became sick with 7.9 percent mortality.[20]

I was fortunate to find an eyewitness with firsthand experience. Margaret St. Louis, an articulate senior citizen of Ottawa, was, in 1918, an 18-year-old volunteer army nurse stationed at Reading, England. Even today, she remembers with sadness the events of those months, although her future husband was one of her patients.

"It happened so suddenly. In the morning we received an order to open up a new unit for flu and by night we'd moved into a converted convent. Almost before the desks were out the stretchers were in — 60 to 80 to a classroom. We could hardly squeeze between the cots. And oh, they were so sick!

"They came from a nearby air force base, boys from all over the Empire. Some had been lying unattended for days. They all had pneumonia. We knew those whose feet were black wouldn't live.

"Two classrooms were made into morgues and they were always full. At the time of the Armistice on November 11, the epidemic was at its height, and between 15 and 20 died in each ward every day. It was awful!

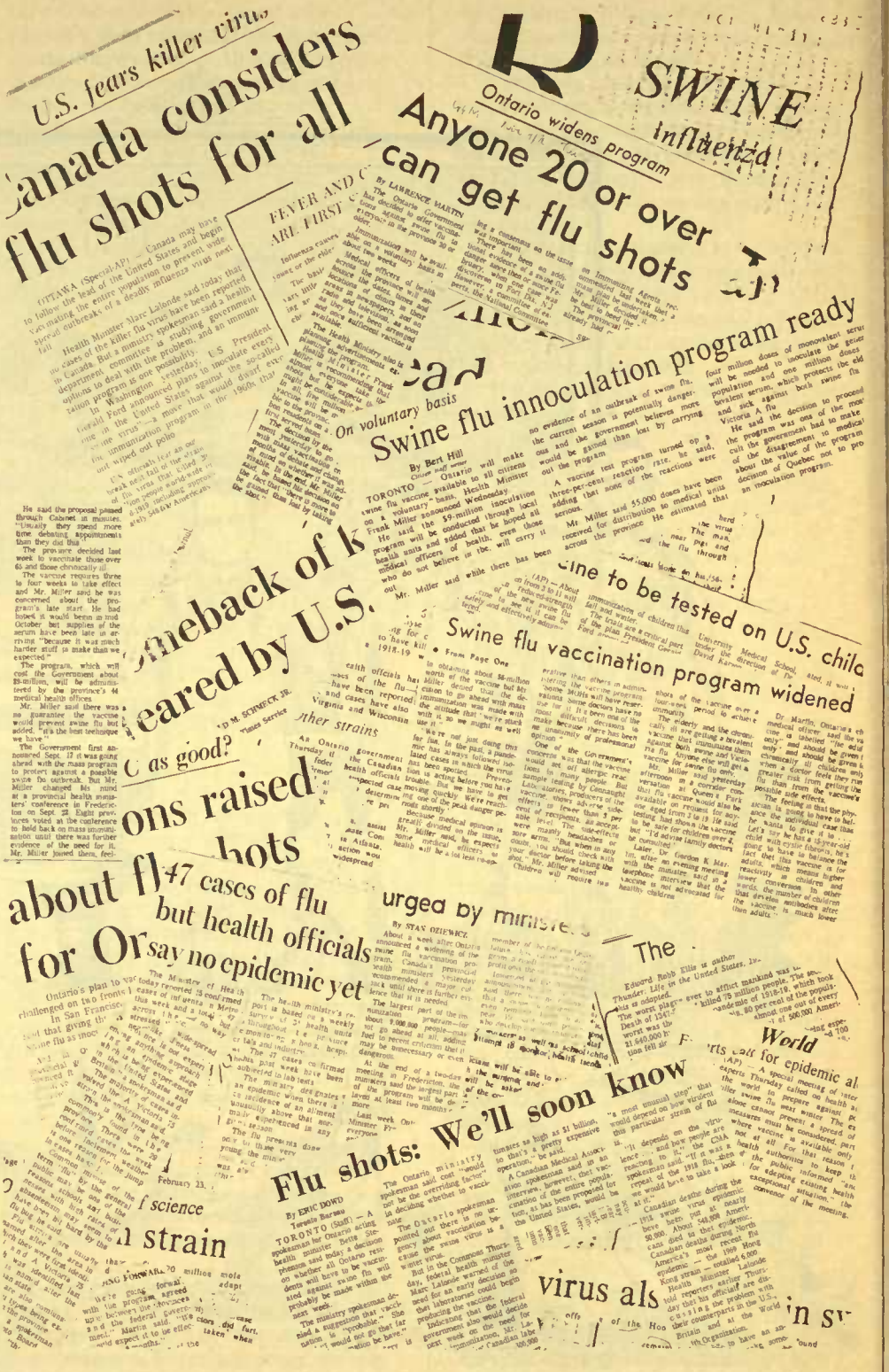
"But we did what we could, and they were wonderful patients. We fed them beef tea and brandy every two hours. They all had to be fed. And we applied linseed poultices and gave them liquid aspirin every four hours. There was only time for a bed bath every second day, but we sponged the sickest (patients) as often as we could.

"Pneumonia jackets were so scarce that we grabbed them from the convalescent and the dead, washed them by hand, and hung them to dry by the open fires. My hands were raw from washing these jackets.

"But the sickest boys I have ever seen were those who had just been burned with mustard gas and then took flu. Their eye sockets were burned; the insides of their ears were burned, and, of course, their lungs. We put those poor lads outside for extra oxygen."

Elsewhere

Bad though it was in the western hemisphere, Spanish influenza was many times worse in Asia, although records are hard to find. The mortality rate for India was six times that of the United States, with 12,500,000 dead, or 4 percent of the population. More Indians died than during all the active combat of the First World



War. Journalists reported that bodies littered the streets, and cemeteries were piled high with corpses. The flu swept like a tidal wave through China, but few had either time or training to record it.

The death rate for South Africa was 27 per 100,000 and, in the ghettos of Cape Town, 2,000 children were suddenly orphaned and destitute.[21] Tangiers was reduced to the level of starvation, and the roads to the cemeteries were blocked with funeral processions.[22]

But the highest incidence of all was on the island of Samoa, where 80 percent of the population was sick at the same time, with 25 percent mortality. A medical unit from Australia could do little more than feed the living and bury the dead.[23]

Conclusion

Like the hurricane it seemed, Spanish influenza had spun itself out by the beginning of March 1919. For those who survived, it took a full year to feel entirely well again. But recover they eventually did. Dr. Mitchell says that for months after he was up and around he wore his socks over his pant legs to keep out the draft. Extreme exhaustion, feelings of weakness, and fragility made the work day long and tiring.

The virus itself, Type A influenza, was not discovered until 1933. Before that time influenza was thought to be caused by Pfeiffer's bacillus. But even today, with our advanced knowledge of viruses, we have no effective prevention or cure for influenza.

Because the virus was most vicious in the stratum of population that carried the greatest responsibility — the wage earners and the parents of young children — it caused more disruption to family life than the war itself.

For those who remember, Spanish influenza was a tragedy of unforgettable proportions, vivid forever in their minds. But for the rest of us, it is a vague name from the past, with no poems, no novels, no plays — just a few scattered statistics to mark its place in history.

The author, now a free-lance writer, earned her R.N. during World War II at the Royal Victoria Hospital school of nursing, Montreal, Quebec.

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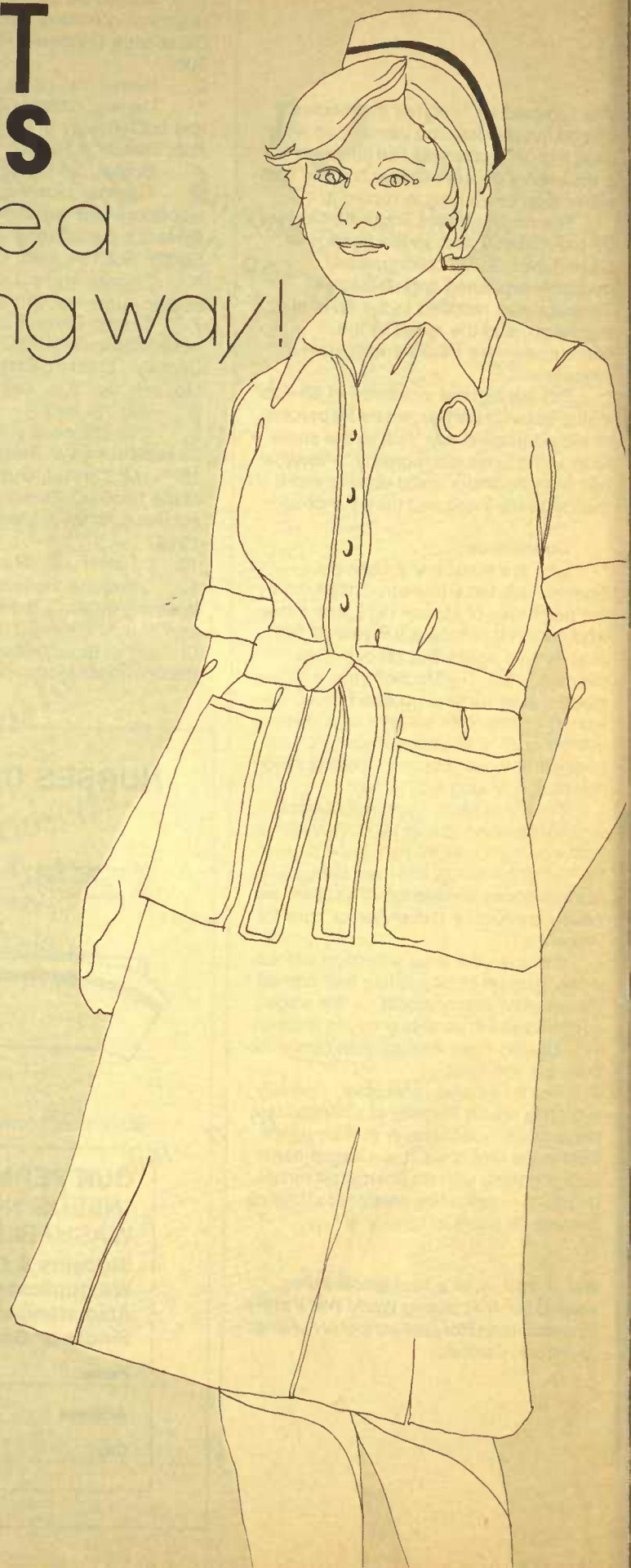
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THE MARKET FOR NURSES -We've come a long way!



Gabrielle Monaghan

The oldest and largest segment of nursing manpower is the diploma educated R.N. This year, several thousand R.N.'s across the country are actively seeking work and are unable to find it. Many of these unemployed nurses are in the province of Ontario. A look at the Ontario experience in the area of nursing manpower offers some interesting insights into developments in other provinces and territories.

The Ontario Experience

- 1962 — Ontario Minister of Health, under public pressure to "do something" about the "growing nursing shortage in Ontario," sets up special committee with representatives from Ontario Hospital Association, College of Nurses, Ontario Medical Association, Registered Nurses Association of Ontario and Ontario Hospital Services Commission (Ewart Committee) *RNAO suggestion that major statistical study be done is vetoed by committee members.*
- 1963—Ewart Committee Report finds evidence of "definite shortage of nurses" and recommends that number of nursing school graduates be doubled from 2,500 to 5,000 within five years. *Nurse members of committee suggest shortage may not be as acute as report suggests.*[1]
- 1967 — Chairman of the OHA Committee on Hospital Schools of Nursing, Charles Black, says: "The greatest single problem facing our hospitals today is an acute and increasing shortage of nurses. Statistics indicate beyond any contradiction the critical nature of the present shortage."[2]
- 1972 — active unemployment among R.N.'s entering labor market for first time (September, 1971) less than four percent according to "Report of a preliminary survey to explore the nursing employment situation."[3]
- 1974 — reports persist through summer months of shortage of R.N.'s in Metro Toronto area.
- 1974 — Ontario College of Nurses predicts widespread unemployment among nurses in that province.[4]
- 1976 — approximately 4,300 persons expected to qualify as R.N.'s after writing CNATS exams in Spring. Approximately 200

job openings available. Reports indicate number of nurses looking for nursing positions could reach close to 10,000 by end of year.[5]

Supply and Demand

The demand for nursing manpower is an offshoot of the demand for health manpower and should, therefore, be considered within the context of the health services system. These services, like other public services such as roads and schools, compete among themselves for their share of the tax dollar. In recent months it has become increasingly evident that there are definite limits on these resources and competition has become more active.

Spending priorities are determined by many factors, some of them only remotely related to health. Two of the variables that influence demands upon the health services include the perceived needs of the population and their perception of the efficacy of medical care since, for the most part, the consumer continues to receive these services at the order of a physician. Implementation of universal federal medicare in the late 1950's removed price as a mechanism for rationing the allocation of health care. The effect of this move is still being felt by the health sector as a whole and by the nursing profession as part of this system.

The Burgeoning Health Field

Before 1960 the health sector was a traditional service industry with a ceiling on attainable output, limited technology and the potential of science poorly applied in its organization. However, a value reconciliation occurred in the implementation of the various Medicare Acts; the idea that health care could and should be delivered to all as a right, and that this was a necessary condition for a democratic society, became generally accepted. The provincial government, as a central decision-making body, took a leadership role in building hospitals and encouraging hospitals to upgrade. The industry took off in rapid expansion, new technology was adopted as quickly as it became available and there was an enormous increase in the demand for personnel. In some instances government consultants encouraged hospitals to increase the nursing complement on their staff. There was a subjective feeling that the demand curve for nurses was rising very rapidly. However, it would seem that the growth in nursing opportunities was less vigorous than it appeared.

New Health Occupations

Each wave of technological growth brought its own group of staff: technicians in cardiopulmonary assessment, renal dialysis, etc. But nurses, who should have had a comparative advantage in these occupations, did not co-opt these jobs although the work often offered significant advantages over nursing for some women, e.g. the absence of week-end and shift duty. Why nurses did not move into these occupations has not been given much attention but a case could be made that they are members of a traditional authoritarian occupation subject to arbitrary control and organization. It has been widely held that members of such a society are stunted in creativity and do not adapt well to changes in the social, economic or technical climate.[6]

The Authoritarian Profession

Weir (1932) found that "the discipline in training schools is unnecessarily severe."[7]

Robson (1967), in a study of the characteristics of women recruited into nursing, found that less than half were lower class girls with high grades, and more than half were upper class girls with low grades. He found also that security was more important to these women than creativity or self development and that nursing directors felt that raising academic standards would attract women into the profession who would not make good bedside nurses. Personality traits disapproved of in the nurse applicant were "skittishness" and "not sufficiently respectful."[8]

Mussallem (1965) deplored the fact that nurses were required to leave school when "their marriage became known to the school authorities."[9]

As a group, then, nurses have been judged to be obedient, conservative, neither adaptive nor creative. Their superiors appear to feel that these are desirable attributes in the nurse. It is little wonder that during the 1960's the sphere of nursing activities in hospitals, where most nurses are employed, became relatively narrower, rather than more varied. The demand for nurses did increase, as the health care system expanded, but nurses were restricted to the nursing service area of the hospital. It is even possible that many of them, unable to cope without further training with the increasing complexity of the hospital, left the profession and contributed to the phenomenon known as nursing turnover.

Turnover in Nursing

In his report to the Committee on the Healing Arts, (1970) Murray equates turnover with a "pseudo-shortage." He found that the feeling among hospital administrators that there was a shortage of nurses arose from the fact that they were continually seeking R.N.'s to replace those who quit after a relatively short period of employment and that although the vacancies were quickly filled (except in summer) the psychological impact of the quitting caused a subjective sense of shortage.[10]

At that time (1965), Ontario had the fourth lowest turnover rate* (57.3%) for graduate nurses in Canada.[11] A look at the national turnover rate reported by Statistics Canada shows that, with few exceptions, it has been dropping each year since then. The Canadian Nurses Association, in a submission to the Royal Commission on the Status of Women in 1968 referred to the shortage of nurses as "fictitious." In retrospect, it seems that the CNA was right.

In his Report , Murray comments on the "ambiguous and scanty facts permitting very little in the way of well-supported conclusions" concerning nursing manpower supply and demand and points out that "it seems to be a foible of human nature that the fewer facts that are known about a particular issue, the more emotional is the reaction to it."[12]

Lacking relevant data, any number of theories may be cited to explain why hospitals were always looking for staff:

- It was the era of the Feminine Mystique and work for married women was not socially approved.
- Wages were low; there was no standard remuneration for experience, and hospitals

** A study of turnover rates for all female employees of one large Canadian bank in 1966 shows an overall rate of 38% as contrasted with 60% for all graduate general duty nurses in Canada in 1965.*

Figure 1

Professional nurses registered in Canada, by employment status and highest level of educational preparation, 1974

Highest level of educational preparation	Employed in nursing	
	Number	Percent
Diploma program leading to R.N.	105,532	82.0
Post-basic diploma/certificate	12,705	9.9
Baccalaureate degree	9,719	7.6
Master's or higher degree	719	.5
Total	128,675	100

Source: Research Unit, CNA

paid different rates.

• Nurses are traditionally considered a very mobile group — but this mobility may have been the result of nurses moving from one hospital to another in the same area in search of better salaries or quitting to avoid working during a pregnancy, since maternity leave was the exception rather than the norm. Or, their geographic mobility may have been related to that of their husbands.

Mulling over these theories makes it obvious just how far we have come...

Discontented Nurses

There is some evidence that nurses have often been unhappy in their jobs. Mitchell (1971) found that only 66% of R.N.'s would choose nursing if the choice could be made again, compared with 93% of university professors.[13] Advancement within the system was limited by their lack of education. In 1968 only .5% of nurses were qualified to the Master's level, and only .01% had doctorates (See Figure I). Pepperdene (1976) showed that nursing careers are determined by the system and the extent and kinds of choices the system offers.[14]. It seems clear that the nature of the market for nurses in the sixties was not well understood. The shortage was fictitious. Wages were too low to encourage many women into the nursing workforce. Turnover was a symptom of poor working conditions, the absence of standardization and the lack of maternity leave and child care facilities. However, toward the end of the sixties, nursing began to catch up with other occupations. Four factors involved in this "catching up" process can be singled out. These include:

1. Collective Bargaining

With the advent of collective bargaining, wages increased and, probably, employment also increased. Turnover in Ontario hospitals began to drop in 1967, about the time that maternity leave was being written into contracts.

2. Staffing Campaigns

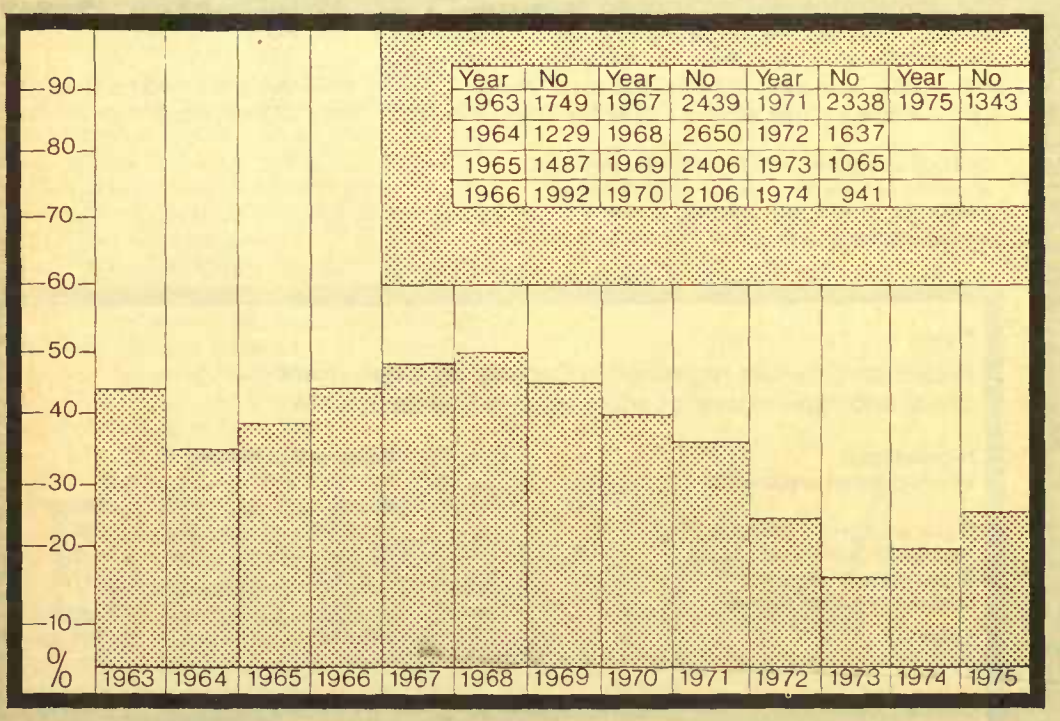
The Toronto hospitals brought an influx of R.N.'s from outside the province — mainly from the United Kingdom. Initial registrants from outside the province formed a significant percentage of total initial registrants — as high as 50% in 1968 (See Figure 2). That there was still a shortage of R.N.'s in summer can be explained by a price offer curve applied to nurses — as the wage rate rose, R.N.'s desired more work initially but as it continued to rise they could afford to shift to less hours of work and more leisure. Other factors such as the extension of Unemployment Insurance benefits to nurses meant that nurses who needed it had the same income maintenance as other workers.

3. Specialization and Economies of Scale

The introduction of modern management and production techniques in hospitals allowed the use of less highly specialized workers and reduced the number of R.N.'s

Fig. 3
Total Nursing Assistant Registered in Ontario 1963-1975
(Source: College of Nurses)

1963	8,103
1964	9,541
1965	10,959
1966	12,223
1967	13,988
1968	14,907
1969	18,358
1970	23,044
1971	24,413
1972	26,213
1973	27,277
1974	28,911
1975	30,544



Year	No	Year	No	Year	No	Year	No
1963	1749	1967	2439	1971	2338	1975	1343
1964	1229	1968	2650	1972	1637		
1965	1487	1969	2406	1973	1065		
1966	1992	1970	2106	1974	941		

Fig. 2
Initial Registration of Out-of-Province Graduates in Ontario 1963-1975.

required. Nurses found that demands for their labor were restricted to areas where legislation prevented those workers from working. The number of these areas tended to shrink. (See Figure 3).

4. *Nursing Education Moves to C.A.A.T.S.*

At the end of the sixties hospital training schools began to be phased into the Colleges of Applied Arts and Technology as nursing education moved into the general education stream. The education program for R.N.'s was cut by one third — from three years to two — and in both 1971 and 1972 there were two graduating classes of nursing students at Ontario teaching centers — graduates of the two-year and of the three-year programs. The effect was to increase graduations by 52% in 1971 and by 42% in 1972 over the previous years. (See Figure 4)

Nursing in the Seventies

The present unemployment in nursing is the result of many factors. Because of their lack of experience, nurses have been relatively powerless to plan their destiny as a profession. Low pay, shift work and the stigma attached to working mothers combined to keep women out of the workforce for many years. Although the Nursing Manpower Task Force lists twenty agencies collecting statistics on nursing, the few figures available are neither very clear nor very useful. Response to the perceived shortage has been to train or import more nurses rather than to get those already trained back into the workforce.

It is fairly obvious that society's priorities as expressed in government policy have shifted. Today the emphasis is on investment in transportation, energy and conservation. There is a demand for economies in the health field that, in turn, is causing layoffs among R.N.'s. However, in facing this crisis the nursing profession appears to be maturing and adopting organizational solutions. An employment agency job information center has been started by the RNAO and each day the press carries advertisements for out-of-province and south-of-the-border employers who are interviewing and recruiting in Ontario. Although it may be sad to lose these nurses one can't but envy them the chance to practise in another setting and those who do return will no doubt bring back fresh ideas.

Need for Planning

Recognizing that the weakest section of economic planning is that dealing with the capacities of people, considerable investment in planning from a firm data base is essential. If large numbers of nurses emigrate we may find ourselves short-staffed again when there is some easing of the present restraints: we must be careful not to repeat the mistakes of the sixties. Today, the emphasis in the health delivery system is shifting away from remedial care, towards health promotion and prevention. It is clear also that R.N.'s are not prepared for a lifetime's work by one-time certification.

At the present time there appears to be a shortage of highly trained people to manage the increasing complexity of some areas of the health service such as data processing and planning. At the same time, higher education for those capable and interested, needs to be made more accessible through an open door policy and greater financial support to students. Possible sources of funds include "health" lotteries, provincial hospital pension plans and a co-insurance charge added to patients' accounts.

Since it will ultimately benefit most from the better qualified work force, the health sector should provide the leadership that is needed now.

Fig. 4
Graduations of Nurses in Ontario 1970-1974.
(Source: College of Nurses).

Year	Diploma Schools	University Schools
1970	3220	137
1971	☆4907	163
1972	☆4576	177
1973	3957	243
1974	3950	268

★ Effect of Double Graduation

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Gabrielle Monaghan, (R.N., Richmond School of Nursing, Dublin, Ireland; B.A., Laurentian University, Sudbury, Ontario) says it was the realization that many of the predictions made by nursing leaders in the sixties were coming true in the seventies, that made her start thinking about the "Market for Nurses." She points out, however, that the employment situation for nurses today is complicated by the "greater personal freedom and responsibility inherent in higher salaries."

The author is in her second (intern) year of the Hospital Administration Program offered by the University of Toronto and working at Belleville General Hospital in Belleville, Ontario. Her studies are sponsored by the Government of Newfoundland.

Clinical Wordsearch no. 3

This is another in a continuing series of clinical wordsearch puzzles relating to different areas of nursing, by Mary Elizabeth Bawden (R.N., B.Sc.N.) who presently works as Team Leader in the Rheumatic Diseases Unit, University Hospital, London, Ontario.

Solve the clues. The bracketed number indicates the number of letters in the word or words in the answer. Then find the words in the accompanying puzzle. The words are in all directions — vertically, horizontally, diagonally, and backwards. Circle the letters of each word found. The letters are often used more than once so do not obliterate them. Look for the longest words first. When you find all the words, the letters remaining unscramble to form a hidden answer. This month's hidden answer has five words. (Answers page 31)."

P L N H U M I D I F I E R R I A N X
O U T A H C L U B B I N G S S R A A
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U B L O O D G A S C I O E S B U L H
R R O P C N O W O T R N U I R L S T
A E E T R C A L A B P C R T O O I O
L A V Y A R D R I S U S U I N B S M
D T L S L E I F Y M K E B E C M A U
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A I A S S I A T I A U A O C O R C N
I N N E T T N I R L M N N A G M E P
N G R S A U C D U L O P C R E L L L
A I Y E S S E A E U R A H T N A E E
G C N F H C R L L D O I U G I R T U
E P M U T U P S P E N N S K C O A R
A S T H M A E K O M S A L P O E N A
C H E Y N E S T O K E S Q O B U R L

1 A chronic disease characterized by dyspnea, wheezing and a sense of constriction of the chest *(6)*
2 Caused by presence of air in the pleural cavity; may be surgical, spontaneous, or follow a chest injury *(12)*
3 A series of tests, such as vital capacity, which measures the effectiveness of lungs *(9, 8)*
4 Usually occur 12-20 times per minute *(12)*
5 pO_2 or pCO_2 *(5, 3)*
6 That volume of air which passes in and out of the lungs in each respiration *(5)*
7 When made of iron, it can really take your breath away during a power failure *(4)*
8 Small chambers where the exchange of O_2 and CO_2 takes place *(7)*
9 That portion of the brain where the respiratory center is located *(7)*
10 A type of carcinoma that originates in the bronchi *(12)*
11 Truom (anagram)
12 #11 composed of new and actively growing tissue *(8)*
13 Enlargement of the finger tips which may result from congenital heart anomalies *(8)*
14 Breathing characterized by increasing and decreasing rate followed by a period of apnea *(6, 6)*
15 20% of normal room air *(6)*
16 Sometimes too loud in hide-and-seek *(9)*
17 This clot is a real mover *(7)*
18 Being poked in them is like having your leg pulled *(4)*
19 A hereditary disease characterized by an over-production of thick tenacious mucus and an abnormal secretion of sweat *(6, 8)*
20 Between trachea and bronchioles *(8)*
21 Inflammation of the trachea *(10)*
22 Chronic obstructive lung disease *(4)*
23 Congestive heart failure *(3)*
24 Noises; not related to trains *(5)*
25 See #24 *(8)*
26 Inflammation of the pleura *(8)*
27 Caused by friction of the two pleural membranes *(7, 3)*
28 Made Smith Brothers' 'drops' famous *(5)*
29 What chimneys and cigars have in common *(5)*
30 Raccen (anagram)
31 Absence of respirations *(5)*
32 An exudate produced by a #28 *(6)*
33 Difficulty breathing *(7)*
34 Collapse of all or a portion of a #7 *(11)*
35 Asian or Swine *(9)*
36 Physiotherapy to remove exudate from the lungs *(8, 8)*
37 Dampens the air but not your enthusiasm *(10)*
38 When #32 is bright red *(11)*
39 Its chief constituent is mucin *(5)*
40 Spoken *(4)*
41 Pertaining to Cyrano *(5)*
42 Nostrils *(5)*
43 What smokers pollute; where castles are built *(3)*
44 Suffering's partner *(4)*
45 As necessary *(3)*
46 Quantum Sufficit *(2)*

Names and Faces



Huguette Labelle, CNA president for the 1974-76 biennium, has resigned as Principal Nursing Officer with Health and Welfare Canada to accept a new position in the federal government's Department of Indian and Northern Affairs.

Her new title is Director General, Policy, Research and Evaluation Branch, Indian and Eskimo Affairs Program, Department of Indian and Northern Affairs. The appointment became effective October 12, 1976.

In accepting the post, the former Principal Nursing Officer said that one of the reasons for the move was her belief that nurses have a great deal to contribute in the way of unique expertise in many areas — not just in the health care field.

Florence Gass recently retired as the Director of Nursing at Victoria General Hospital, Halifax, Nova Scotia after 21 years service. After completing post-graduate work at McGill School of Nursing, she was assistant director of nursing at the Victoria General Hospital, Victoria, B.C., before working in Halifax.

Father Jean-Marc Daoust S.J. of Montreal has been appointed Executive Director of the Canadian Catholic Health Association. Since 1966, he has been very active in health care through the promotion of pastoral care and the development of hospital chaplincy education programs in health care institutions.

Helen Sabin, Executive Director of the Alberta Association of Registered Nurses from 1960 to the present, recently announced her retirement. Her tenure of office has seen the number of practicing registered nurses of the A.A.R.N. grow from 4,382 (1960) to 11,804 (1976).

Her administrative approach has been one of experience, fairness, common sense, flexibility and courage to back up her decisions. She has been noted for integrity, demonstrated adherence to ethical principles and soundness of moral character. She



has been able to avoid the common syndrome of "we have always done it that way" and instead has dealt effectively with the demands of changing situations. Her coordinating activities have included speaking for nursing, interpreting Association policy and seeking solutions to mutual concerns with members, governments , associations and organizations external to the A.A.R.N.

Jeanette Funke (R.N., Regina Gray Nuns Hospital school of nursing; Dipl. P.H., B.N., McGill University, Montreal; M.Sc.N., University of Colorado, Denver) assistant professor, University of Alberta school of nursing, has received a grant from the Toronto Sick Children's Hospital Foundation, covering a 22-month period, to study "The Reliability and Validity Testing of Indicators of Maternal Adaptive Behavior." She is the project director.



Yvonne Chapman has been appointed Executive Director of the Alberta Association of Registered Nurses effective November 1, 1976. Chapman brings to this position a broad background and a depth of experience in nursing as well as in the affairs of the Alberta Association of Registered Nurses. She is well known to members and colleagues in the health care field through her employment as Director, Collective Bargaining Program for the past six years.

Originally from North Sydney, Nova Scotia, she received her basic education at the Victoria General Hospital School of Nursing, Halifax. Post-basic education includes a diploma in Nursing Service Administration from the University of Saskatchewan and a Baccalaureate Degree in Nursing from McGill University.

Prior to accepting employment with the A.A.R.N. in 1970, Chapman held a variety of positions in hospitals and public health agencies from general staff, to supervisory, to director of nursing positions and also as a consultant with the Saskatchewan Hospital Association.

Anna Claire MacAdam (R.N., B.A.) is serving a two-year tour of duty with MEDICO, a service of CARE, in Afghanistan. She will be working in a supervisory capacity furthering the education of local nurses, in a new hospital in the Afghan capital of Kabul.

Prior to joining MEDICO, MacAdam worked at the Camp Hill Hospital in Halifax and nursed in Peru with CUSO.

New Appointments

The Faculty of Nursing, University of Alberta, Edmonton, has recently appointed to its staff:
Amy M. Zelmer (R.N.; B.Sc.N.; M.P.H.; Ph.D., Michigan State University) as Dean of the Faculty of Nursing.
Marilyn Jean Campagna (R.N.; B.Sc.N., University of Windsor) as lecturer;
Maria-Rubllie Glenn (R.N.; B.Sc.N., University of Alberta) as lecturer in medical-surgical nursing.

Carol May Mitchell (B.N., University of Manitoba) has been appointed lecturer in the Faculty of Nursing, University of British Columbia.

Elaine Marie Mullen (R.N.; B.Sc.N.; M.S., Duke University, North Carolina) has been appointed lecturer in the School of Nursing, Lakehead University, Thunder Bay, Ontario.

Lakehead University, Sudbury, Ontario announced the appointments of **Alice Jope** (B.Sc.N.) and **Carol Woods**(B.Sc.N.) as lecturers in the School of Nursing.

Robert Donahue has been appointed Acting Director of the Collective Bargaining Program of the Alberta Association of Registered Nurses effective November 1, 1976. He brings to his new position a background in journalism, public relations and his experience as Employment Relations Officer for the A.A.R.N.

Jane Bennett (B.Sc.N.) has been appointed Employment Relations Officer with the Collective Bargaining Program of the Alberta Association of Registered Nurses. Her background includes general duty, inservice education and emergency room nursing.

Calendar

January

Counselling the emotionally/mentally disturbed patient — conducted at the Clarke Institute of Psychiatry, Toronto, Ontario from Jan. 25 to April 12, 1977. Fee: $75. For information contact: *Mrs. Dorothy Brooks, Chairman, Continuing Education Programme, Faculty of Nursing, 50 St. George St., Toronto, Ontario, M5S 1A1.*

The Grieving Process and the Dying Process — an evening course given at the University of Toronto on January 26 - March 16, 1977. For information contact: *Mrs. Dorothy Brooks, Chairman, Continuing Education Programme, Faculty of Nursing, 50 St. George St., Toronto, Ontario, M5S 1A1.*

February

Nursing in Inflammatory and Ulcerative Disease of the Gastro-intestinal Tract. To be held on Feb. 14-15, 1977 at the University of Toronto. Fee: $50.00 For information contact: *Mrs. Dorothy Brooks, Continuing Education Programme, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ont., M5S 1A1*

The Eleventh Health Care Evaluation Seminar is being hosted by the Division of Community Health Science, University of Calgary on Feb. 6-11, 1977. It will focus primarily on Maternal and Child Health. Applications from health professionals, administrators and others concerned are invited. For information write: *Christina Berglund, Seminar Coordinator, Division of Community Health, University of Calgary, 2920 - 24 Ave. N.W., Calgary, Alberta, T2N 1N4.*

Supervision in Community Nursing to be held on Feb. 14-18, 1977 at the University of Toronto. Fee:$200.00 For information contact: *Mrs. Dorothy Brooks, Continuing Education Programme, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ont., M5S IAI.*

Cardiac Pacing Symposium - February 23, 1977. To be held at University Hospital, London, Ontario. Cosponsored by the Canadian Council of Cardiovascular Nurses, Medtronic of Canada Ltd., and Continuing Education, Faculty of Medicine, University of Western Ontario. Fee: $10. For further information, contact: *Leslie Key, Chairman of Planning Committee, 196 Cromwell Street, London, Ontario. N6A 1Z5.*

March

Symposium on Infant Nutrition, a closed circuit telecast sponsored by Health Projects International, will be shown simultaneously in Toronto (Hyatt Regency Hotel), Montreal (Bonaventure Hotel) and Vancouver (Four Seasons Hotel) on March 23, 1977. Nurses are invited and there is no fee. For information contact: *HPI, 200 Madison Ave., New York, N.Y. 10016, (212) 683-7620.*

Adapted Physical Activity to the Rehabilitation Process — 1st International Symposium to be held at the Chateau Frontenac, Québec on March 17 - 19, 1977. Papers will be presented on such topics as: aging, the mentally retarded and the perceptually handicapped. For further information, contact: *S.I.A.P.A., Centre de Réadaptation du Québec, 525 boulevard Hamel, Québec, Canada, G1M 2S8.*

Mental Retardation — a one-day conference for nurses held on March 9 and 16, 1977 at The Hospital for Sick Children, Toronto. Tuition:$ 20. For information, contact: *The Co-ordinator of Nursing Education, The Hospital for Sick Children, 555 University Avenue, Toronto, Ontario. M5G IX8.*

April

Tenth Conference of Operating Room Nurses of Greater Toronto to be held April 25-27, 1977 at the Skyline Hotel, Toronto, Ontario. For information contact: *Mrs. Eleanor Conlin, Convener, Publicity Committee, 25 Fidelia Cres., Bramalea, Ontario, L6L 3P7.*

Nursing the Paediatric Emergency — a two-day conference conducted by the nurses of the Emergency Department at The Hospital for Sick Children, Toronto on April 28-29, 1977. Commonly encountered medical-surgical problems with guidelines to assessment, priorities and nursing action, as well as health teaching are included. Tuition:$35. For information, contact: *The Co-ordinator of Nursing Education. The Hospital for Sick Children, 555 University Avenue, Toronto, Ontario. M5G 1X8.*

Symposium on Coping with Cancer to be held at the Royal York Hotel, Toronto, Ontario on April 24-26, 1977. Topics to be discussed include: cancer prevention, screening for cancer, helping the newly diagnosed patient, palliative care and other related topics. *Contact your provincial nurses' association for details and registration forms.*

May

International Council of Nurses 16th Quadrennial Congress to be held in Tokyo, Japan from May 30 - June 3, 1977. Theme: New Horizons for Nursing. For information write: *Canadian Nurses Association, 50 The Driveway, Ottawa, Ontario, K2P 1E2.*

The Third National Conference for Autistic Children to be held in Regina, Saskatchewan on May 12-14, 1977. For information contact: *The Conference Chairman, 95 Hudson Drive, Regina, Saskatchewan, S4S 2W1.*

Victorian Order of Nurses' Annual Meeting to be held on May 5-6, 1977 at the Chateaú Laurier Hotel, Ottawa. For information contact: *Victorian Order of Nurses for Canada, National Office, 5 Blackburn Ave., Ottawa, Ont., KIN 8A2.*

Canadian Hospital Association National Convention to be held on May 10-12, 1977 at Quebec City. For information contact: *The Canadian Hospital Association, 25 Imperial St., Toronto, Ont. M5P 1C1.*

Annual Meeting of the American Thoracic Society to be held in San Francisco, California on May 15-18, 1977. For information contact: *American Thoracic Society, 1740 Broadway, New York N.Y. 10019.*

June

Nursing Care of the Sick Newborn to be held at The Hospital for Sick Children, Toronto on June 13-17, 1977. A five day conference for nurses to increase their knowledge of the premature and newborn infant. Clinical practice not provided. Tuition: $80.00. For further information, contact: *Hilda Rolstin, Co-ordinator, Nursing Education, The Hospital for Sick Children, 555 University Avenue, Toronto, Ontario, M5G 1X8.*

Canadian Tuberculosis and Respiratory Disease Assoc. Annual Meeting to be held on June 13-15, 1977 in Moncton, New Brunswick. For information contact: *The Canadian Tuberculosis and Respiratory Disease Association, 345 O'Connor Street, Ottawa, Ontario, K2P 1VP.*

Canadian Medical Association Annual Meeting to be held in Quebec City on June 20-25, 1977. For information contact: *The Canadian Medical Association, 1867 Alta Vista Drive, Ottawa, Ontario,K1G 3Y6.*

August

World Federation for Mental Health - 1977 Congress, "Today's Priorities in Mental Health," to be held in Vancouver, B.C. from August 21 - 26, 1977. The focus of the meeting will be on finding ways to make health systems work for all the people, including the mentally ill. Techniques of Health By The People will be emphasized. For further information contact: *Secretariat, World Federation for Mental Health, Health Sciences Centre Hospital, 2075 Wesbrook Place, The University of British Columbia, Vancouver, B.C. V6T 1W5.*

Resumes are based on studies placed by the authors in the CNA Library Repository Collection of Nursing Studies.

Research

- **Consumer Opinions.**

A comparison of consumers' and providers' opinions of community and health services in a northern Alberta town. Seattle, Wash., 1975. Thesis (M.A.) U. of Washington by *Margaret A. Seymour.*

In 1972, a pilot project in community health services was begun in a northern Alberta area. It was to serve people of diverse cultural backgrounds. The literature indicated that there is often a wide discrepancy between the opinions of the health team and the consumers on priorities in health care. When consumer opinions are ignored, health programs can, and do fail.

This study, by means of a questionnaire, was to: 1. determine consumers' opinions regarding community and health services in an isolated area in northern Alberta; 2. determine the opinions of the health team in the same area with regard to the same services; 3. compare and contrast the two. Findings indicated a high degree of interest in health care planning, a desire by both consumers and the health team for more feedback from the health services board with regard to planning and a fairly high degree of agreement between the opinions of the consumers and the health team regarding problems in the area surveyed.

- **Senior Citizens**

A Study of Health and Related Needs of Senior Citizens in Two Housing Complexes. Independent study by *Myrtle L. Kirstine (M.Sc.N.)*

In this descriptive study, community health nursing personnel interviewed 122 senior citizens — 68 residents of one newer senior citizen low rental apartment building, designated building A; and 54 residents in an older similar building, designated building B. Comparisons were made between the health needs of residents in each building, their concerns and opinions regarding the housing, their health and the future. Nurses were asked to rate residents' coping abilities in the present situation and to determine the residents' need for nursing and other care.

The primary purposes were to gather data for planning community health nursing services for elderly persons, to examine the feasibility of an extended nursing role in caring for the elderly, to gather data on the adequacy of this type of Ontario Housing as perceived by the residents, and to collect data that could assist in maintaining the elderly in independent living arrangements. A secondary purpose was to identify learning needs of nurses for assuming an extended role in the care of elderly persons.



Building A had been occupied for less than one year and building B had been occupied for seven years. Findings were that residents in building B were generally older, more likely to be living alone as widows or widowers, were less likely to have accurate knowledge of services such as ambulance, fire and police departments. The older group in building B engaged in more social activities within the building whereas the younger group in building A engaged in social acitivities mainly outside the building.

Residents of both buildings had similarities: almost all came from the local area and had family or friends nearby; the majority attended a local physician whom they had seen in recent months. Most residents reported medical conditions related to heart and circulatory disorders; the older group reported more arthritic and rheumatic complaints. Both groups were prone to neglect dental care. On the average, the older group in building B took more prescribed medications and had less knowledge regarding these than the younger group in building A. Both groups were considered to have poor knowledge of contraindications and side effects. Most residents adopted a philosophical and stoic outlook toward their health and the future.

Most senior citizens, residents of both buildings, were very happy with their living accommodation. This was reflected in their positive remarks. Some members of the older group in building B did express the need for dining facilities in the building and/or some type of convenience food shop where they could buy staples.

Interviewers rated the coping abilities of the older group in building B, lower than the younger group in building A, particularly in access to or ability to use public or private transport, in their understanding of medications and in deterioration of mental faculties.

Regular nursing visits and visits if ill were the most frequent suggestions given by residents and nursing personnel as being the means whereby nurses could be helpful in caring for these senior citizens and /or in preventing crises.

There was some hesitation on the part of nurses to suggest nursing visits when residents were under medical care, although it was believed that nursing visits would be helpful.

Conclusions were drawn relating to housing for senior citizens, general health care and an extended role for community health nurses.

- **Education**

Exploration of the Opinions of Nursing Faculty Regarding Change. Toronto, Ont., 1975. Thesis (M.Sc.N.), University of Toronto by *Dorothy L. Eden.*

This project was undertaken to explore the opinions of nursing faculty to change. Government legislation forcing diploma schools of nursing into general education was the impetus behind this study. Three former hospital schools of nursing that were moving into the same educational institution were selected. This educational institution had had its



own nursing program for some years. A descriptive study was designed, so the expressed opinions of the nursing faculty already in general education could be compared with the opinions of the nursing faculties moving into general education.

Two questionnaires were given to a sample comprised of full-time nursing teachers who did not have administrative functions. The first questionnaire was given after representatives of all faculties had been working on a common curriculum; the second one was administered five months after the common curriculum had been instituted. Where appropriate, the responses were computer analyzed for means, medians, modes and frequency distributions. Content analysis was done on responses to open-ended questions.

The findings indicated that in most areas the former hospital respondents had more concerns than the members of the nursing faculty in general education. The hospital respondents indicated that their role as a teacher had changed and they were more dissatisfied with their jobs. Both groups were satisfied with being part of a large multi-discipline school, with qualified staff to teach non-nursing subjects and with their relationships with students. Concerns for both groups of respondents were in the areas of curriculum and teaching responsibilities. The two samples perceived that the students had adjusted easily and well, and identified some factors contributing to this adjustment. Statistical analysis of the individual variables indicated a trend toward general homogeneity within the total current faculty group.

Books

Nursing in Canada: Canadian Nursing Statistics 1975 Catalogue 83-226 Annua (Bilingual) (Soins infirmiers au Canada: Statistique des soins infirmiers) is now available. Price $2.10. Orders should be sent to: Publications Distribution, Statistics Canada, Ottawa, K1A 0T6.

Law Every Nurse Should Know by Helen Creighton. 327 pages. Philadelphia, W.B. Saunders Company, 1975.
Reviewed by Mary Tkach, Core Year Nursing Instructor, Wascana Institute of Applied Arts and Science, Regina, Saskatchewan.

As members of the health care profession, nurses are becoming increasingly aware of the rights of the patient who is receiving care as well as the professional rights of nurses. Legal aspects of health care are an important concern.

Though much of this book is devoted to a definition of terms in reference to American statutes and laws, it provides the nurse with many definitions of legal terminology and case studies to improve her understanding of legal jargon. Just as medical terminology is difficult for lay persons to understand so legal terminology becomes a puzzle to health care personnel unfamiliar with its use and expression. Here, legal terminology in relation to health care workers is made more clear and concise. The book also promotes understanding of the legal aspects the nursing profession must consider.

One chapter of the book is devoted to Canadian Law and Legal Practice. Differences between American and Canadian laws and statutes are outlined. Recent information on the expanding role of the nurse practitioner, the nurse's role and responsibility as a member of a professional body provincially and nationally, and her role as an employee of health care institutions is included. The major difference and one of significant importance to Canadian nurses is the infrequency with which the nurse alone will be charged with negligence in Canada. Such forms of legal action are brought against health care institutions rendering them liable for all those activities performed by its employees.

The scope of this book includes information directly pertaining to the nurse and her role and responsibility in carrying out her daily activities as an employee of a variety of agencies.

Unfortunately, the greatest part of this book is devoted directly to the American governmental statutes and is not directly applicable to the Canadian situation. However, it is useful in illuminating the legal implications of nursing practice. This book would be a most informative reference for students of nursing who are presently receiving only minimal instruction regarding the legal aspects of the profession.

Since an awareness of legal rights of the individual has shown a sharp increase in recent times, it is hoped that in the future more information can be included about Canadian law specifically. It is also hoped that each nurse, functioning in one of the many and varied roles of her profession will take responsibility for understanding the legal aspects of her role and the responsibilities she carries with that role as an employee within the health care field.

Care of the Cardiac Surgical Patient by Ouida M. King, St. Louis, The C.V. Mosby Company, 1975.
Approximate price $13.60.
Reviewed by Elaine Parfitt, Lecturer, University of Alberta, School of Nursing, Edmonton, Alberta.

An important overall feature of King's book is that a basic level nurse would require some background knowledge and assistance in order to best appreciate some of its content.

King's discussion of embryology makes it easier to understand the congenital cardiac defects. A good brief review of anatomy, physiology and embryology is included in the test.

There is also a good review of diagnostic procedures used in cardiac surgery. These would be more pertinent to nurses who have studied at the post basic level.

King's descriptions of diseases requiring surgery are concise in providing background. I found the diagrams and illustrations excellent. Her description of the surgical procedures gives plentiful aid to the cardiac surgical nurse.

I would like to have seen this book provide more in-depth consideration of patient care in cardiac surgery. The psychosocial needs of these patients was given minimal consideration.

It is unusual to see a chapter on electricity or electronic equipment given in a nursing textbook. We could have more of this since we are making increasing use of such equipment in nursing generally.

Exercise physiology is a very large area and the chapter on it is a substantial summary. While lacking depth, a good attempt has been made here to be thorough.

The teaching plan for cardiac surgical patients is brief but complete. However, an emphasis should have been placed on the individualization of patient teaching with reference to conditions for effective learning.

In general, I found King's book excellent on the technology of cardiac surgery. Such a competent work has its place as a major reference in cardiac surgical units. It was both an honor and a challenge to review.

Young Inner City Families: Development of Ego Strength under Stress by Margaret M. Lawrence, 139 pages, New York, Behavioral Publications, 1975.
Reviewed by Mrs. A.N. Kelly, Halifax Infirmary, School of Nursing, Halifax, Nova Scotia.

This book deals with an interdisciplinary approach to problems relating to inner city or ghetto families. It also attempts to show how ego strength is developed in individuals shaped by the stresses of ghetto life.

Lawrence outlines three factors influencing ego development, calling them Nature, Nurture and Noxia. She states that these three factors play outstanding roles in the lives of developing infants and children in the Harlem Hospital community.

The author defines Nature in reference to man as the 'constitutiona basis with which to work ... the groun through which all development is woven.' She points out that a person's constitutional makeup is also affecte by genetic and congenital factors. She defines Nurture as 'being cared for, being loved, being seen as a person in one's own right, having contact in one's daily life prove that people car be trusted and that the world is a stable and friendly place.' Noxia is referred to as trauma or severe injury, physical or emotional.

Lawrence attempts to show how the ego is developed (Nature, Nurture), how it is stressed (Noxia) and how it survives (development of ego strength), and uses case histories to exemplify her theory. Two extensive case studies are presented, those of Hassan and Pedro.

Hassan's case includes a brief background on the development of his problem, and essentially portrays a multi-agency approach to his problem. Pedro's case study deals with an individual child, gives an in-depth personal and family history, outlines the treatment attempted, and comments on its effectiveness and follow-up. In both these case studies the author effectively relates the three factors — Nature, Nurture and Noxia to the development of the child. In her discussion of treatment in these two case studies and others, the author describes therapeutic education, provided through a multidisciplinary approach.

As a Canadian I found the many titles of the personnel involved in the multidisciplinary approach very confusing, as I was unaware of the roles inherent in the titles. This affected my concentration. I would have preferred an increased emphasis on the case histories — I finished the book wanting to know more background information and more about the approach.

This book would prove most useful to those in community nursing who are interested in the psychosocial effects on child development. On the whole, however, I do not feel it is useful in diploma programs except perhaps as a senior project on child development.

The 1976 Index for *The Canadian Nurse*, vol. 72, is available on request. Write to *The Canadian Nurse*, 50 The Driveway, Ottawa, Ontario, K2P 1E2.

Library Update

Publications recently received in the Canadian Nurses' Association Library are available *on loan* — with the exception of items marked R — to CNA members, schools of nursing, and other institutions. Items marked R include reference and archive material that does *not* go out on loan. Theses, also R, are on Reserve and go out on Interlibrary Loan only.

Requests for loans, maximum 3 at a *time*, should be made on a standard Interlibrary Loan form or by letter giving author, title and item number in this list.

If you wish to purchase a book, contact your local bookstore or the publisher.

Books and documents

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Library Update

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City Prov.

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